ANNUAL REPORT 2019

PŪRONGO Ā-TAU

National Maternity Monitoring Group

The 7th Annual Report for the NMMG

NATIONAL MATERNITY MONITORING GROUP

DISCLAIMER

This publication is intended to inform discussion and assist 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. Data for the period 1 January 2019 to 31 December 2019 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

Ki a koutou ngā whānau kua tākoha mai ō koutou pikitia mō tēnei pukapuka, nāia te reo o mihi ki a koutou.

The NMMG wishes to thank all of the families who generously provided photos for this publication.

NGĀ KAI O ROTO

CONTENTS

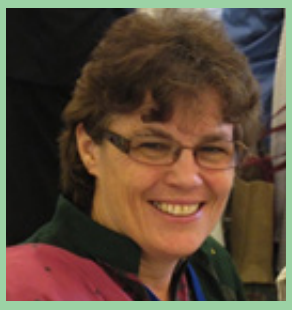
NGĀ WHAKAPOTO

ABBREVIATIONS USED IN THIS REPORT

DHB	District Health Board
HQSC	Health Quality & Safety Commission
HRC	Health Research Council
HWNZ Health	Workforce New Zealand
IOL	Induction of Labour
LARC	Long-acting Reversible Contraceptives
LMC	Lead Maternity Carer
MERAS	Midwifery Employee Representation and Advisory Service
MMPO	Midwifery and Maternity Providers Organisation
MMWG	Maternal Morbidity Working Group
MQI	Maternity Quality Initiative
MQSP	Maternity Quality and Safety Programme
MUAG	Maternity Ultrasound Advisory Group
NE	Neonatal Encephalopathy
NMMG	National Maternity Monitoring Group
NSU	National Screening Unit
PHO	Primary Health Organisation
PMMRC	Perinatal and Maternal Mortality Review Committee
POAC	Primary Options for Acute Care
PROMPT	Practical Obstetric Multi-Professional Training
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists

KŌRERO NĀ TE TUMUAKI

MESSAGE FROM THE CHAIR



It has been a privilege to Chair the National Maternity Monitoring Group (NMMG) during 2019; to work, alongside my colleagues, 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 pre-term birth, maternal mental health, place of birth, and equitable access to contraception, with an overarching concern of redressing maternity service inequities.

The NMMG welcomed the opportunity to make a submission to the Health and Disability Review. Our submission had a strong equity focus noting important values for inclusion in New Zealand's future public health and disability system as being patient and whānau focussed, equitable, evidence-based, culturally responsive, with care delivered close to home whenever possible, and a focus on prevention rather than cure.

The NMMG met with Hon Julie Anne Genter in August 2019 to discuss our key priorities, implementation and monitoring of recommendations made by the Ministry of Health funded maternity groups directly affecting health outcomes for women and babies, and review of the role of the NMMG to align with the Maternity Whole of System Action Plan 2019-2023. We also raised with the Ministry of Health significant concern at the ongoing crisis in our midwifery workforce in both the community and core DHB maternity services, impacting on the quality and safety of maternity services.

The NMMG were encouraged that the sector had the opportunity to attend Child and Youth Wellbeing Strategy workshops run by the Ministry with the Department of Prime Minister and Cabinet (DPMC) aimed at continuous improvement of the health sector system and services that support the health and development of infants, children and youth.

Along with the many positive activities of the year, as highlighted in our last annual report, it remains disappointing that the sector is still not achieving the Maternity Standards. Of particular 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).

Also of concern is the absence of a central depository for clinical guidelines in New Zealand, as illustrated in the key findings of a stocktake/gap analysis of maternity-related guidelines in use in the maternity sector nationally commissioned by the NMMG in May 2019. The NMMG consider national maternity clinical guidelines as being a key component in setting standards based on the latest clinical evidence or best practice and enabling consistency in clinical maternity practice.

Looking towards 2020, the NMMG is dedicated to continuing to support the Ministry of Health in delivery of the maternity work programme and working with the Ministry to develop a strategic direction to influence the way maternity services are provided at the grass roots level.

2020 is the International Year of the Midwife and the Nurse which provides an important opportunity to advocate to strengthen midwives and the midwifery profession – let's celebrate!

Judith McAra-Couper

KŌRERO NĀ NGĀ HĀKUI

MESSAGES FROM THE NMMG CONSUMER REPRESENTATIVES

Jeanine Tamati-Elliffe

I joined the NMMG around five years ago. In my first few meetings I remember feeling both nervous, but optimistic. Optimistic that I would be contributing to a much needed discussion, as a wāhine Māori consumer passionate about improving the maternity health system to ensure the quality and safety of care for women and their pēpi is at the forefront, but nervous about the many complexities and challenges needing to be uncovered that this would involve.

As a (well-experienced) user of our maternity services here in Aotearoa over the past 17 years, I have received nothing but amazing advice, loving support and safe and professional care from all of the wonderful midwives and practitioners that I have had the privilege to encounter. However, I worry about whether my own daughter will ever experience this same level of care and support in the not-so-distant future given the continuing crisis still evident in our maternity workforce.

My hopefulness for seeing change in our maternity health system has waned largely due to the unresolved issues which face our workforce. Our midwives must be valued for the important role they play in ensuring we, as wāhine and whānau, are able to give our pēpi the best possible start to their journey here in te ao mārama. It is my hope that in 2020, the International Year of the Midwife, this ongoing issue is finally settled.

This wish was often reflected in the many passionate discussions had and contributions to forums alongside other consumers involved in the Maternity Quality and Safety Programme (MQSP) over the past year and featured also in our NMMG discussion with Hon Julie Anne Genter. To counteract this anxiety felt in regards to the state of our workforce, I also felt invigorated in the knowledge that a whole of system Maternity Action Plan is on its way. An action plan where Māori values, needs and aspirations are at the core. As a wāhine Māori there is nothing more important to me than being able to access culturally relevant, culturally aligned and culturally appropriate services for my whānau and I.

Alongside the key priorities of the NMMG focused on maternal mental health, place of birth, pre-term birth, and equitable access to contraception, at the forefront of my mind is the unique experience of Māori women and their whānau. If we are to truly address issues that affect the maternity quality and safety of women and their pēpi, then we must think beyond the physiological experience for these wāhine and their whānau and highlight the importance of improving the bicultural competence and confidence of our maternity and wider health workforce.

If we are serious about addressing inequities in Aotearoa, then we must ensure our models of 'best practice' include the authentic adoption of bicultural frameworks that strengthen bicultural practice - because of the value it brings to practitioners navigating intercultural contexts.

Best practice is ensuring manaakitanga is at the centre of our maternity health system and a focus of all that we do – not just at the service provision level, but recognising its importance at a funding level.

Best practice is trusting the intergenerational values of iwi Māori and in particular, mana whenua that they have the solutions and strategies that best align to meet the health needs of not just Māori people, but all people.

Best practice is valuing our midwifery workforce to ensure they are supported to do what they need to do in order for māmā, pēpi and their whānau to thrive.

Best practice is recognising that sometimes we need to step back and create space for others – particularly in regards to representation of, and partnership with, tangata whenua in the areas of our health system that need and should have this inclusion.

Best practice is ensuring opportunities for kaupapa Māori pregnancy and parenting initiatives are not just 'exemplars for practice', but become our norm here in Aotearoa. Why? Because they are centred on values that connect us, as humans, to each other - and provide space, reinforced by narratives and tikanga, that strengthen our bond and responsibility to not just the health and wellbeing of our pēpi – but the uniqueness of place-based context: tūrangawaewae. The bonus is, kaupapa Māori initiatives like this are beneficial to both Māori and non-Māori alike - this is evident in the increasing demand for programmes like this around the motu.

Finally, best practice is admitting our faults and that we haven't always got it right. We must remain committed to doing better and being better – and being unafraid to do things differently.

Ka whati te tai, ka pao te tōrea – when the tide recedes, the oystercatcher strikes.
We must be brave and seize the moment in order to create positive change.

Mauri ora, nā

Jeanine Tamati-Elliffe

Isis Martin-Mckay

I joined the NMMG in January 2019, and as one of two consumer members on the group, I have tried to bring service user experience to the forefront of our sometimes-robust discussions. I aim to ensure that the importance of the pregnancy and birth experience as a whole, is not lost amongst the plethora of potential risks and concerns relating to pregnancy, labour, and birth.

It is not uncommon to see the measure of 'quality and safe' services reduced down to achieving and demonstrating 'good clinical outcomes' for mums and babies. When talking to pregnant people about their aspirations for their pregnancy and birth, there is almost an expectation that they will give the accepted mantra of 'I don't care about what happens to me, as long as my baby is safe and healthy.' Of course, we all want babies to arrive safely. However, you cannot provide a quality and safe service without delivery of care that is respectful, mana enhancing and supports pregnant people and their whānau to experience a pregnancy, labour, and birth that honours and protects the many aspects that are important to them.

Like many members of the group, I am concerned about the continuing loss of physiological birth, as demonstrated in the data received from our 20 DHBs. But, before we point the finger at our services, or women and their 'high risk' bodies, we ought to make sure that we meaningfully understand the experiential, aspirational, social, economic, and cultural influences that contribute to the current birthing culture in Aotearoa.

I am excited to continue my NMMG journey with this dynamic group of people working in partnership with services to help pregnant people and their whānau plan for and experience the best possible pregnancy, labour, and birth regardless of birthplace setting or mode of birth.

Isis Martin-Mckay

TE RŌPŪ O NMMG

ABOUT THE NMMG

The 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 1 January 2019 to 31 December 2019.

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 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

These high-level strategic 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 New Zealand's maternity services.

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

The 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 2019 work programme was aligned to the priorities set out in the refreshed New Zealand Health Strategy[2] and Roadmap of Actions, as well as continuing previous workstreams where further work was required. Together, the MQI, the Maternity Standards, and the New Zealand Health Strategy provide guidance on how the NMMG and maternity stakeholders can work together 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

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.

JEANINE TAMATI-ELLIFFE

Jeanine is a mother of five tamariki and works as a Kaiārahi Māori for Te Waka Pākākano | Office of the Assistant Vice-Chancellor Māori, Pacific and Equity at Te Whare Wānanga o Waitaha | University of Canterbury. In addition, Jeanine is a consumer representative on the Aotearoa Midwifery Project Collective Reference Group and a member of the South Island Child Health Alliance. She is committed to improving health equity for wāhine Māori and their whānau and provides advice, support and expertise to a range of kaupapa including as a a founding member of Māori 4 Kids Inc, a board member for the Brainwave Trust Aotearoa and Poipoia Pūmanawa Inc. As an extension to this community work she runs her own consultancy business and is currently completing her Master in Māori and Indigenous Leadership.

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 the Director of Midwifery at Auckland District Health Board. 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; along with achieving both positive and equitable outcomes for all. We have an outstanding maternity service in Aotearoa but there is work to do to ensure every woman has timely access to midwifery and maternity care tailored to meet her individual needs and those of her whānau.

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.

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).

LESLEY McCOWAN

Lesley is an Obstetrician and Gynaecologist and works in the Academic Department of Obstetrics and Gynaecology at the University of Auckland. She is actively involved in several research projects which focus on reducing stillbirth, and improving outcomes for overweight mothers and their babies and in pregnancies with fetal growth restriction. Her research has a particular focus on reducing inequities in outcomes for New Zealand mothers and babies. She is on the Executive Committee of Te Kahui Oranga o Nuku (NZ Committee of RANZCOG), represents Te Kahui Oranga o Nuku on the Growth Assessment Programme Working Group for ACC and is a Council Member of the New Zealand Health Research Council.

CHRIS McKINLAY

Chris is a Neonatologist at Kidz First Hospital, Counties Manukau, and Senior Lecturer in perinatal health, Liggins Institute, University of Auckland. His clinical and research interests focus on the early determinants of metabolic health and child development, including pregnancy and infant nutrition and growth. He is the New Zealand representative on the International Task Force for Neonatal Resuscitation (ILCOR), and sits on several other national working groups. Chris is committed to the ongoing development of publicly funded maternity and neonatal services that not only deliver the best pregnancy and birth outcomes for women and babies but also improve life-long health.

ISIS MARTIN-MCKAY

Isis is currently the General Manager at Women's Health Action, where she has spent the last 11 years in various roles primarily focussing on maternal and child health. She has a background in public health and enjoys challenging mainstream definitions of success and health. Isis has developed and led several regional and national initiatives and projects aimed at improving women's health care policy and service

JOHN TAIT (EX OFFICIO)

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).

BRONWEN PELVIN (EX OFFICIO)

Bronwen was the Ministry of Health's Principal Clinical Advisor Maternity Services prior to her retirement in March 2020. A midwife with more than 40 years of experience, Bronwen worked as a domiciliary midwife, a community-based Lead Maternity Carer (LMC), a core midwife, and a maternity manager. She was the first national Midwifery Advisor for the New Zealand College of Midwives. She was also the Professional Midwifery Advisor for Nelson Marlborough DHB before joining the Ministry in 2008. Her work in the Ministry involved designing the Maternity Quality Initiative and implementing the Maternity Quality and Safety Programme in DHBs. She was also involved in the original co-design process to set up new funding and contracting for community-based midwives. Bronwen has been collaborating with other midwifery groups, DHBs and consumers to celebrate midwives in 2020 International Year of the Midwife.

HE TIROHANGA WHĀNUI

AN OVERVIEW OF THE NMMG'S RECOMMENDATIONS FOR 2019

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 New Zealand. For example, not all women are able to access first trimester screening, ultrasound scanning, social workers and antenatal clinics.

Several things need to happen to ensure the continued improvement of maternity services in 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 would like to see action from key maternity stakeholders.

Preterm Birth

The NMMG considers that reducing preterm birth rates and reducing death and infant morbidity related to preterm birth is a priority.

We recommended that the Ministry commission research into national strategies to reduce preterm birth rates, reduce inequity and improve outcomes associated with preterm birth as part of the proposed maternity research programme, supported by the Health Research Council (HRC).

Maternal Mental Health

All New Zealand women need equitable access to appropriate mental health services during pregnancy and postpartum. The NMMG recognises the importance of taking a cross-sector approach to providing effective mental health services for women.

We recommend that the Ministry undertake a Maternity Consumer Survey (last conducted in 2014) and Survey of Bereaved Women (last conducted in 2015) as soon as possible, with the inclusion of a question related to maternal mental health.

We expect to see DHBs report on mental health referral and treatment pathways and will ask DHB Planning and Funding divisions to advise what percentage of their mental health budget is allocated to providing maternity mental health services.

Place of Birth

The NMMG supports strengthening primary maternity services including timely, equitable access to community-based primary maternity care as appropriate for women. We would like to see the provision of appropriate services so that parents feel safe to birth in non-hospital environments, including parents receiving evidence-based information to inform their decisions about place of birth.

We recommend DHBs, Primary Health Organisations (PHOs) and the Midwifery Council of New Zealand report on how women are informed of the full range of place of birth options; and outline methods used to promote primary birthing facilities for appropriate women.

Equitable access to contraception

All women need access to free contraceptive services from the immediate postpartum period. We are dedicated to investigating equity of access to Long-acting Reversible Contraceptives (LARCs) by reviewing information from DHBs about availability and funding of LARCs, and exploring and promoting examples of good practice where DHBs ensure equity of access to LARCs for all consumers, including groups of women with poorer maternity outcomes.

The NMMG would like DHBs to report on access to postnatal contraception for all women, processes in place for supporting women to make informed choices, and services available that support women to obtain their choice of contraception.

The NMMG will continue to monitor the Ministry's progress towards incorporating postnatal contraception in its work programme.

Connecting Sector Leadership

The NMMG will work with the Ministry to progress the implementation and monitoring of maternity advisory groups' recommendations and encourage the adoption of a mechanism for prioritising recommendations to DHBs.

Workforce

The NMMG will continue to highlight the ongoing crisis in New Zealand's midwifery workforce in both the community and core DHB maternity services impacting on the quality and safety of maternity services and outcomes for mothers and babies.

TE HŌTAKA MAHI

THE NATIONAL MATERNITY MONITORING GROUP'S 2019 WORK PROGRAMME

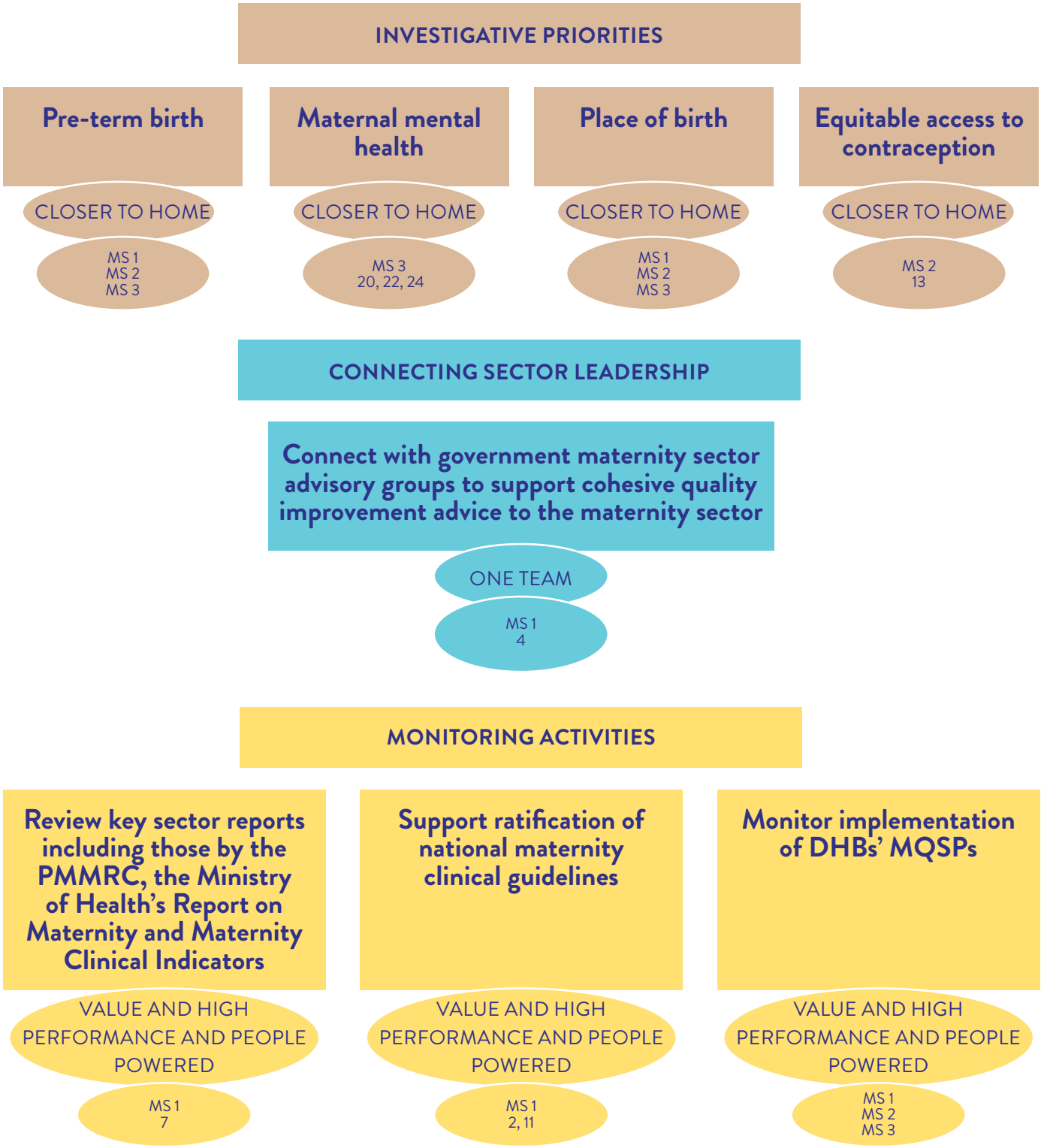


Figure 3: The NMMG's 2019 Work Programme

TATA KI TE KĀINGA | CLOSER TO HOME

MĀTAIHIA

INVESTIGATE PRETERM BIRTH

Our aim for 2019 was to initiate a programme to reduce preterm birth rates, reduce inequities and reduce death and infant morbidity related to preterm birth.

The World Health Organization defines preterm birth as being babies born alive before 37 weeks of pregnancy are completed. Complications associated with preterm birth are the leading cause of death among children under five years of age. Three-quarters of these deaths could be prevented with current, cost-effective interventions. There is also significant inequity in the follow-up of infants at risk of neurodevelopmental problems and insufficient focus on school readiness assessment and support.

In May 2019 the NMMG discussed a report on the work undertaken in the area of prevention of preterm birth and preterm related perinatal death in New Zealand within the previous five years. This discussion highlighted the shortage of research available relating to preterm birth in New Zealand.[3]

3 https://www.auckland.ac.nz/en/liggins/in-the-community/clinical-studies/clinical-studies-preterm-babies/about-preterm-studies.html

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE DID AND OUR KEY FINDINGS

We provided feedback to the Ministry

We recommended that the Ministry commission research to improve outcomes associated with preterm birth as part of the proposed maternity research programme supported by the HRC.

The NMMG endorsed the work led by the Liggins Institute, University of Auckland in developing quality improvement initiatives relating to preterm birth that had a national focus.

TE PAE TATA

THE CHANGES WE EXPECT TO SEE NEXT

The NMMG will champion the development of a national programme to reduce preterm birth and preterm-related perinatal death and to reduce inequities associated with preterm birth by providing appropriate services for priority populations and advocating for mandatory cultural competency workshops across the maternity sector. This will assist in redressing the health inequities experienced by Māori, Pasifika and Indian mothers and their babies.

We would like to see DHBs report on:

- current activities to reduce preterm birth and associated inequities, and follow-up services for babies and attendance rates (including by ethnicity);
- processes in place to follow up women with previous preterm birth; and
- processes in place to ensure early engagement of women who have had a preterm birth with a midwife in a future pregnancy.

MĀTAIHIA

INVESTIGATE MATERNAL MENTAL HEALTH

Our focus for 2019 was to work collaboratively to champion maternal mental health

All New Zealand women need equitable access to appropriate mental health services during pregnancy and in the postpartum period. Women with existing mental health issues are at risk of mental health issue 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 safety and wellbeing of their babies. Women remain vulnerable to poorer mental health outcomes up to one year postpartum, including postnatal depression and suicide.

In the eleventh Perinatal and Maternal Morbidity and Mortality Review Committee (PMMRC) report, the PMMRC noted that suicide "continues to be the leading single cause of maternal death in New Zealand." New Zealand's rate of maternal suicide is seven times higher than that of the United Kingdom. Māori women experience an increased risk of suicide and are over-represented in the number of maternal suicides. Improving access to primary mental health services for all women with a focus on Māori women, and ensuring that services are available for serious and acute episodic mental illness and culturally appropriate are important ways to support mothers in the first postpartum year, to build wellbeing and live healthy lives for themselves, their babies and their whānau.

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE DID AND OUR KEY FINDINGS

We liaised with the Maternal Morbidity Working Group

We liaised with the Maternity Morbidity Working Group (MMWG) suggesting that they recommend to the PMMRC that an analysis be undertaken on information available on where to place system interventions to prevent maternal suicide.

The MMWG advised an in-depth analysis had been undertaken by the PMMRC, which was summarised in the Maternal Mortality Key Findings in the PMMRC 12th Annual Report dated June 2016.[4]

We raised the issue of prioritisation of pregnant women accessing mental health services

We noted that women with mild to moderate depression during pregnancy and in the postpartum period continued to be a concern highlighted by a number of primary care organisations developing bids for mental health funding to roll out new counselling services through general practices, which could provide a pathway for these women to access care. We raised the issue of prioritisation of pregnant women accessing mental health services, including allowing referrals from midwives, and whether there were counsellors skilled in working with pregnant women at the Primary Care presentation to the Auckland Faculty Board of the College of General Practitioners.

4 https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3391/

We received an update from the Ministry of Health Mental Health and Addiction Directorate

We received a written update from the Mental Health Addiction Directorate for maternal health including:

- support for maternal mental health wellbeing;
- expanding access and choice of primary mental health and addiction support;
- pregnancy and parenting services; and
- mental wellbeing support for parents and whānau.

The NMMG look forward to a representative of the Ministry Mental Health and Addiction Directorate attending a meeting in 2020 to provide an update on access to funding for maternal mental health.

TE PAE TATA

THE CHANGES WE EXPECT TO SEE NEXT

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

We would like the Ministry to include a question about maternal mental health in both the next Maternity Consumer Survey (last conducted in 2014) and the next Survey of Bereaved Women (last conducted in 2015).

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

- what are the criteria for admission to a secondary care mental health service?
- what proportion of referrals for mental health assessment and treatment are accepted or declined due to lack of services or because they would be more appropriately managed in the community?
- what facilities are available for inpatient care during pregnancy and in the postpartum period, including provision for babies to stay if appropriate?
- what challenges are making pathways difficult?
- what is the extent of unmet need?
- how are DHBs providing support to primary care to manage women with mild to moderate depression during pregnancy and in the postpartum period?
- what measures are being taken to ensure all women (and particularly those at increased risk) are being screened for mental health concerns during pregnancy and postpartum?
- are mechanisms being implemented that raise awareness/deliver education among midwives so they feel safe/confident to discuss/address mental health wellness with women and their whānau?
- what systems are in place to ensure midwives are well supported to care for women with complex mental health needs, particularly those with complex issues, such as suicidal tendencies?

We will ask DHB Planning and Funding divisions to advise what percentage of their mental health budget is allocated to providing maternity mental health services.

MĀTAIHIA

INVESTIGATE PLACE OF BIRTH

An important focus for 2019 was to support the strengthening of primary maternity services including timely, equitable access to community-based primary maternity care

Approximately 10 percent of New Zealand women birth at primary maternity facilities, with many of these maternity units located in rural areas. Rates of birth at primary facilities are decreasing: the number of women birthing at primary birthing units declined from 15.1 percent in 2006, to 9.9 percent in 2015. Evidence shows that for healthy women with low-risk pregnancies birthing at a primary birthing unit compared with a hospital increases the likelihood of normal vaginal birth with no difference in infant mortality.[5] The NMMG strongly supports the promotion of primary birthing units for healthy women with low-risk pregnancies.

5 Scarf VL, Rossiter C, Vedam S, Dahlen HG, Ellwood D, Forster D, et al. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. Midwifery. 2018;62:240-55.

Ā MĀTOU MAHI, Ā MATOU HUA

WHAT WE DID AND OUR KEY FINDINGS

We wrote to Counties Manukau Health

The NMMG wrote to Counties Manukau Health about the importance of continuing to promote primary maternity services and we highlighted the opening of the Nga Hau Mangere Birthing Centre in March 2019. We encouraged Counties Manukau Health to collaborate with private partners to ensure facilities continue to be sustainable.

We asked the Ministry to facilitate a Place of Birth Workshop

The NMMG requested that the Ministry support the development of clinical practice guidelines for place of birth, including facilitating a workshop to encourage multi-disciplinary discussions on place of birth.

We supported the initiative of providing pasteurized donor milk banks for preterm and sick babies

The NMMG wrote to the New Zealand Lactation Consultants Association supporting the provision of pasteurized donor milk banks for preterm and sick babies throughout New Zealand. We wrote to the Ministry recommending that they work with DHBs to establish a national donor milk bank service.

TE PAE TATA

THE CHANGES WE EXPECT TO SEE NEXT

We requested that the Ministry include questions in the next Maternity Services Consumer Satisfaction Survey relating to how accurately and completely women are informed of place of birth options.

We would like to see the provision of appropriate services so that parents feel safe to birth in non-hospital environments, including parents receiving evidence-based information to inform their preferences about place of birth.

We will request that DHBs, PHOs and the Midwifery Council of New Zealand report on:

- how women are informed of the full range of place of birth options; and
- outline methods used to promote primary birthing facilities to healthy low risk women.

We will request that DHBs report on what supports are in place to encourage Lead Maternity Carers (LMCs) to use primary birthing facilities for healthy low-risk women (e.g. provision of free Practical Obstetric Multi-Professional Training (PROMPT) courses/ facilitating registrations).

MĀTAIHIA

INVESTIGATE EQUITABLE ACCESS TO CONTRACEPTION

An important focus for 2019 was to highlight that all women need access to free contraceptive services from the immediate postpartum period

Of women who are living in low or middle-income countries and have given birth in the past year, 95 percent hope to avoid a pregnancy in the next two years, but only about one-third of these women are using contraception.[6] We believe that New Zealand women living in low and middle-income neighbourhoods experience similar circumstances. Further, a birth-to-pregnancy interval of less than 12 months is associated with the highest risk of adverse health outcomes for the mother and child.[7] Therefore, provision of contraception to enable spacing of pregnancies has a vital part to play in reducing adverse health outcomes for mothers and babies.

The NMMG noted the discourse relating to access to contraception for teenage women living in low or middle-income neighbourhoods in New Zealand and that it often did not take into account a Māori worldview. We recommend:

- that conversations be centered on personal choice, supportive whānau, and strong community connections;
- being innovative when offering support;
- that practitioners are trained in working in Māori and multi-ethnic communities.

We are dedicated to investigating equity of access to LARCs by reviewing information from DHBs about availability and funding of LARCs, and exploring and promoting examples of good practice. For example, where DHBs have achieved equity of access to LARCs for all consumers, including groups of women with poorer maternity outcomes.

6 Gaffield ME, Egan S, Temmerman M. It's about time: WHO and partners release programming strategies for postpartum family planning. Glob Health Sci Pract. 2014:2(1):4-9. http://dx.doi.org/10.9745/GHSP-D-13-00156

7 Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. Lancet. 2012;380(9837):149-156. Doi: 10.1016/S0140-6736(12)60609-6

Ā MĀTOU MAHI, Ā MATOU HUA

WHAT WE DID AND OUR KEY FINDINGS

We liaised with the Ministry on equitable access to contraception

We met with the Population Health and Prevention Directorate who provided an update on work being undertaken by the Ministry in relation to equitable access to contraception. We were advised that funding of $6 million per annum had been allocated to DHBs for a contraceptive access initiative to improve equity of access to contraception for women on low incomes. It was noted that new national contraception guidelines were being developed to improve the quality and consistency of contraceptive services for all women, which will be available from late-2020.

Example of good practice

The NMMG highlighted an example of good practice of access to contraception in Northland where a combined approach to preconceptual care (including information and advice on sexual health, contraception, pregnancy and health lifestyle options) was being offered and women were encouraged to engage with GPs and nurse practitioners.

TE PAE TATA

THE CHANGES WE EXPECT TO SEE NEXT

The NMMG will request that DHBs report on access to postnatal contraception for all women, the processes in place for supporting women to make informed choice, and the services that are available to support women to enable their choice of contraception.
The NMMG will continue to monitor the Ministry's progress towards introducing postnatal contraception on is work programme.

The NMMG continued to support 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;
- that the Ministry 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;
- that the National Screening Unit (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 whānau is undertaken. If gaps are identified, that the MUAG recommends the Ministry develop appropriate resources; and
- regular information sharing across the sector and with stakeholders and the public.

NMMG was encouraged to note that the New Zealand Obstetric Ultrasound Guidelines were published on the Ministry's website in December 2019 and the remaining recommendations will be implemented through the Whole of Maternity System Action Plan 2019-2023. The Plan had not been published at the time of writing.

MAHI TAHI | ONE TEAM

KIA MAHI TAHI, KIA WHAKAKOTAHI

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

An important focus for 2019 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 government agencies on maternity issues. These include 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 priorities for implementation. The NMMG is well-placed to connect and support the coordination of groups with responsibilities for providing maternity advice and services, such as LMCs, DHBs, consumers, and professional colleges.

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

Overview of matters discussed at meeting with the Associate Minister of Health

The NMMG met with Hon Julie Anne Genter in August 2019. The meeting focused on our key priorities, the implementation and monitoring of recommendations made by Ministry of Health funded maternity groups, and the need to review of the role of the NMMG so that it is closely involved with the Maternity Whole of System Action Plan 2019-2023. The Plan had not been published at the time of writing.

We made a submission to the Health and Disability System Review

We made a submission to the Health and Disability System Review. Our submission had a strong equity focus noting important values for inclusion in New Zealand's future public health and disability system:

- patient and whānau focused;
- equitable;
- care delivered close to home whenever possible;
- evidence-based; and
- culturally responsive and a focus on prevention.

We also noted we would like to see investment in, and support for, innovative collaborative research between academics, clinicians, iwi and community providers to explore experimental, aspirational social, economic and cultural influences that contribute to the birthing culture in Aotearoa New Zealand.

We liaised with the Director-General of Health

We met with the Director-General of Health in May 2019 to discuss the governance and leadership role of the NMMG and our concern that women in New Zealand were not able to access a nationally consistent, comprehensive range of maternity services (e.g., access to first trimester screening, ultrasound scanning, maternal mental health services and antenatal clinics). The Director-General of Health advised that the Ministry's focus on equity was central to the Maternity Whole of System Action Plan 2019-2023 and the associated allocation of resources.

We wrote to the Director-General of Health in August 2019 to raise significant concerns at the ongoing crisis in the midwifery workforce in both the community and core DHB maternity services, impacting on the quality and safety of maternity services and outcomes for mothers and babies.

We met with the PMMRC to discuss dissemination of recommendations

We met with the PMMRC in October 2019 to discuss a plan for the dissemination and monitoring of recommendations made by all Ministry-funded groups. Following the meeting, a summary of recommendations from the PMMRC, Maternal Morbidity Working Group (MMWG) and NMMG Annual Reports was compiled to inform discussion on the prioritisation of recommendations in early 2020.

TE PAE TATA

THE CHANGES WE EXPECT TO SEE NEXT

The NMMG will work with the Ministry to progress the implementation and monitoring of the maternity advisory groups' recommendations and encourage the adoption of a mechanism for prioritising recommendations to the DHBs.

KIA IHIIHI TE MAHI, KIA WANA TE TANGATA

VALUE AND HIGH PERFORMANCE AND PEOPLE POWERED

AROTAKETIA

REVIEW KEY SECTOR REPORTS

A focus for 2019 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.

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

The NMMG supported the recommendations in the MMWG 2nd Annual Report

We wrote to the MMWG supporting the development of a national guideline for the management of sepsis as a priority, acknowledging that the prioritisation of developing further guidelines would be informed by the maternity work programme.

The NMMG supported the recommendations in the MMWG 3rd Annual Report

We wrote to the MMWG supporting:

- the development of a national guideline for management of placental implantation disorders;
- the MMWG's recommendations relating to hypertensive disorders; and
- the development of resources in close collaboration with consumers to ensure the information meets health literacy standards.

(We noted that from a culturally responsive perspective, this would include providing readily accessible resources in multiple languages to accommodate the needs of New Zealand's diverse communities.)

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

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.

No changes were made to the 20 indicators for the 2018 data, nor the criteria and methods. The data covered the 2018 calendar year and included all pregnancies and live-born babies post 20 weeks' gestation on the National Maternity Collection from the National Minimum Dataset.

Ten years of data from the New Zealand Maternity Clinical Indicators shows positive and negative trends, as illustrated in Figure 4, where positive trends are indicated by a green arrow, and negative trends are indicated by a red arrow.

Figure 4 National trends over time, from the NZ Maternity Clinical Indicators 2009-2018

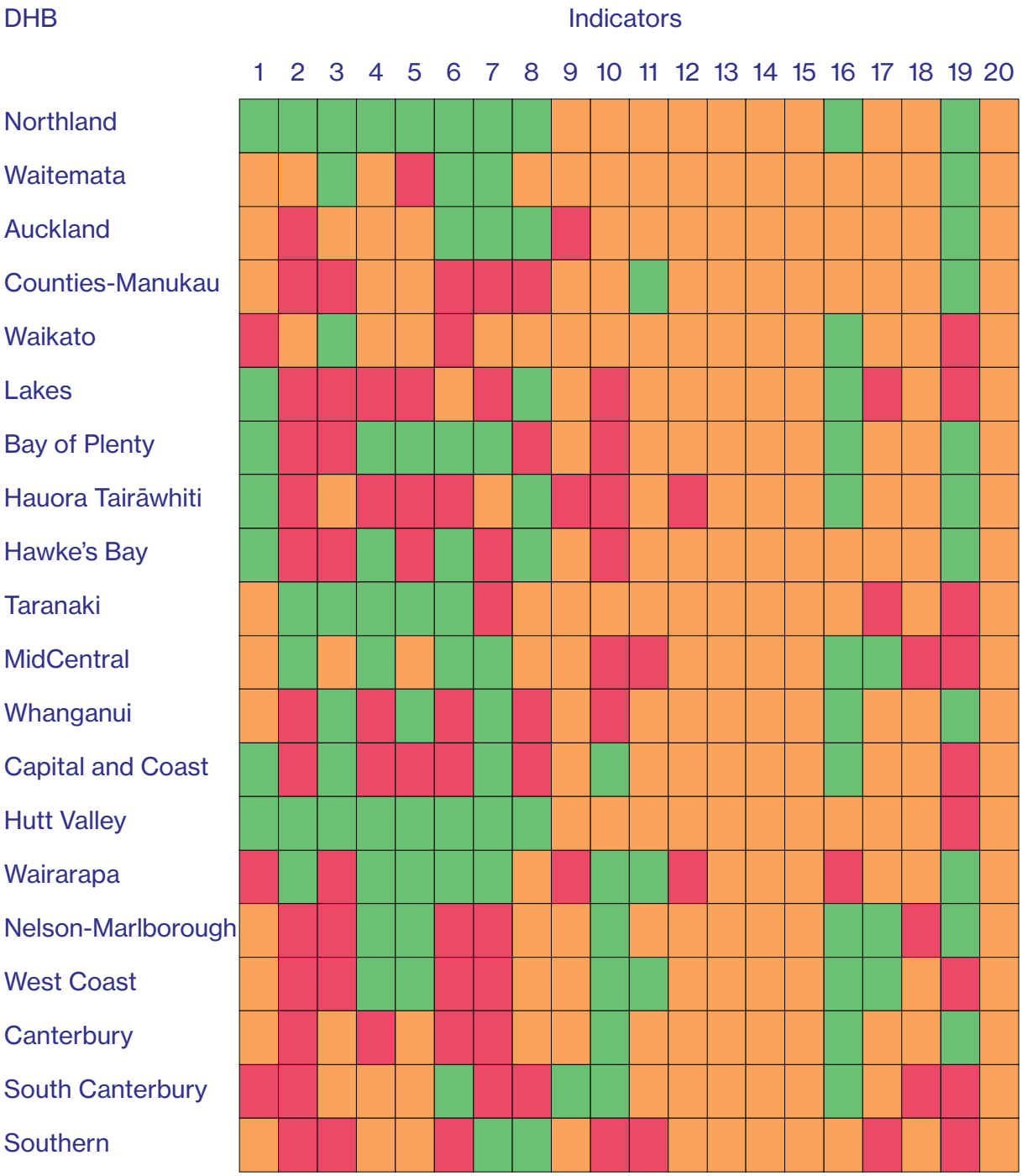
1	↑	Since 2009, more women are registering with an LMC in the first trimester of pregnancy.
2	↓	Fewer standard primiparae are having spontaneous vaginal births, since 2009.
3	↑	Since 2009, a higher proportion of standard primiparae are having an instrumental vaginal birth.
4	↑	Nationally, the percentage of standard primiparae giving birth by Caesarean section has increased since 2009.
5	↑	Standard primiparae undergoing induction of labour has increased since 2009.
6	↓	Standard primiparae are less likely to have an intact genital tract following birth compared to women birthing in 2009.
7	↑	The number of episiotomies being performed on standard primiparae who have no third or fourth degree tear has increased since 2009.
8	—	Standard primiparae sustaining a third or fourth degree perineal tear and not having an episiotomy has remained relatively stable since 2013.

9	—	Standard primiparae sustaining a third or fourth degree perineal tear and undergoing an episiotomy has remained relatively stable since 2009.
10	—	The number of women undergoing a caesarean section under general anaesthetic has remained relatively stable since 2009.
11	—	The number of women requiring a blood transfusion following a caesarean section has remained relatively stable since 2009.
12	—	Since 2009, the number of women giving birth vaginally and undergoing blood transfusion during birth admission has remained relatively stable.
13	—	The number of women diagnosed with eclampsia during birth admission has remained relatively stable since 2009.
14	—	The number of women having a peripartum hysterectomy has remained relatively stable since 2009.
15	—	The number of women admitted to an intensive care unit (ICU) and requiring ventilation during pregnancy or postnatal period has remained stable since 2009.
16	↓	The number of women identified as smokers during the postnatal period has steadily decreased since 2009.
17	—	The percentage of preterm births has remained stable since 2009.
18	—	The percentage of small babies at term (37-42 weeks' gestation) has remained relatively stable since 2009.
19	↓	There has been a steady decrease since 2009 in the percentage of small babies at term born at 40-42 weeks' gestation.
20	↑	There has been a small increase since 2009 in the percentage of babies born at 37+ weeks' gestation requiring respiratory support.

Note: A difference of at least one percent between 2009 and 2018 is considered a better or worse result.

A summary of how DHBs are performing against the NZ Maternity Clinical Indicators in 2018 is provided in Table 1 below.

Table 1: Summary of how the DHBs are tracking against the NZ Maternity Clinical Indicators in 2018 compared to 2017



Green: the DHB has reported a better result against the indicator in 2018 than in 2017.
Orange: the DHB has reported a similar result against the indicator in 2018 and in 2017.
Red: the DHB has reported a worse result against the indicator in 2018 than in 2017.

Note: A difference of at least one percent between 2017 and 2018 is considered a better or worse result for each indicator.

TE PAE TATA

THE CHANGES WE WOULD LIKE TO SEE NEXT

We expect DHBs to review the 2018 New Zealand Maternity Clinical Indicators and the 2017 Report on Maternity and consider how the data applies to the services provided in their areas. We would like DHBs to use their MQSP annual reports to describe how they will respond to any recommendations made in these key sector reports.

AROTURUKITIA

MONITOR THE IMPLEMENTATION OF DHBS' MATERNITY QUALITY AND SAFETY PROGRAMMES

A focus for 2019 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 women's 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.

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

We reviewed each DHBs 2019 MQSP Annual Report

The NMMG was encouraged to note the following highlights:

- Whanganui DHB as an exemplar of good practice in their adoption of kupu Māori (Māori words) and commitment to embracing mātauranga Māori (Māori knowledge and understanding).
- Kaupapa Māori pregnancy and parenting courses across most DHBs.
- LMC Liaison roles.
- teen pregnancy and birthing classes (Manaaki Kano and He Tupua wairoa) at Northland DHB.
- Waitemata DHB Cultural Liaison roles and evidence of response to consumer feedback (e.g., compassionate parking, food and support person staying overnight).
- equity focus applied to the New Zealand Maternity Clinical Indicators.
- the development of a bereavement room at Lakes DHB.
- the use of video technology/telehealth to link with rural health professionals and communities.
- DHB rural LMC support packages.
- West Coast DHB – online access to the Maternal Mental Health Pathway to All Pathway.
- the use of infographics, graphics and photographs made reports consumer friendly.

Although encouraged by highlights, the NMMG would like DHBs to focus on the following areas of improvement over the next reporting period:

- evidence of DHB audit and progress on achieving the New Zealand Maternity Standards.
- the analysis, interpretation and application of DHB data/statistics into quality improvement projects that improve outcomes.
- undertake an audit of DHB LARC services to include the age and ethnicity of women receiving them and the number of LARCs removed in each 12 month period, so trends can be shown.
- data in relation to DHB specialist maternal and infant mental health referrals, declines and access issues.
- evidence of consumer feedback being incorporated into quality improvement projects and the impact on outcomes.

We wrote to the Ministry of Health asking that consideration be given to facilitating a maternity sector group meeting to discuss key themes arising from 2019 DHB MQSP Annual Reports

The NMMG discussed alternative methods for reviewing DHB MQSP reports that could be more helpful in informing NMMG priorities and providing meaningful feedback to DHBs. We wrote to the Director-General Health requesting approval to facilitate a maternity sector group meeting to present key themes arising from 2019 DHB MQSP annual reports and discuss maternity clinical indicators and benchmarking with a goal of linking back to the sector.

The Ministry advised that proposals for reviewing the benchmarking of maternity outcomes would be part of the quality assurance framework review under the Maternity Whole of System Action Plan 2019-2023. The Plan had not been published at the time of writing.

TE PAE TATA

CHANGES WE WOULD LIKE TO SEE NEXT

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 on to assist them with preparing their annual reports.

TA UNAKITIA NGĀ ARATOHU

SUPPORT RATIFICATION OF NATIONAL MATERNITY CLINICAL GUIDELINES

A focus for 2019 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 all DHBs so that best practice is consistently delivered in our maternity services.

Ā MĀTOU MAHI, Ā MĀTOU HUA

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

The NMMG commissioned a stocktake/gap analysis of maternity-related guidelines

The NMMG commissioned a stocktake/gap analysis of maternity-related guidelines in use in the maternity sector in New Zealand. In the development of the stocktake, DHB Maternity Quality Safety Programme (MQSP) Coordinators were asked for information regarding guidelines in use at DHBs, and other maternity sector organisations, including colleges and ACC.

We reviewed the findings in May 2019, which illustrated the absence of a central repository for clinical guidelines in New Zealand. NMMG priorities for the development of maternity-related clinical guidelines, as a matter of urgency, are for small for gestation age (SGA), sepsis and preterm birth.

The NMMG met with ACC in November 2019 to discuss the development of refreshed SGA guidelines. ACC agreed that the principle of developing refreshed guidelines was timely and asked that NMMG take the lead in developing a proposal for submission to the ACC Board for consideration. ACC has agreed to fund refreshed guidelines.

TE PAE TATA

CHANGES WE WOULD LIKE TO SEE NEXT

We would like to see the development of clinical guidelines for SGA, sepsis and preterm birth progress as a matter of urgency. We would like to acknowledge and thank ACC for undertaking work on the SGA guideline.

ĀPITIHANGA 1: HŌKAITANGA KAUPAPA MŌ TE NMMG

APPENDIX 1: TERMS OF REFERENCE FOR THE NMMG

TERMS OF REFERENCE FOR THE NATIONAL MATERNITY MONITORING GROUP, JULY 2016 - JUNE 2019

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