

ALLEN+CLARKE

**EVALUATION OF THE MATERNITY
QUALITY AND SAFETY PROGRAMME**

MINISTRY OF HEALTH

Final Report

30 July 2015



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This report has been prepared by:

Ned Hardie-Boys, Anna Scanlen, Kate Primrose
Allen + Clarke

Dr Susan Lennox and Dr John Marwick
Sky Blue House

Dr Amohia Boulton and Dr Heather Gifford
Whakauae Research Services

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EXECUTIVE SUMMARY

Background

The Maternity Quality and Safety Programme (MQSP) was rolled out across all district health boards (DHBs) from early 2012. It aims to:

- improve local maternity quality and safety
- improve national service improvement tools and support
- establish national priority setting for maternity monitoring and quality and safety
- broaden the scope and visibility of maternity quality activities.

The Ministry of Health (the Ministry) provided funding and guidance to support DHBs to implement local MQSPs. Funding was provided until 30 June 2015, after which time DHBs were expected to operate their MQSPs as business as usual. The Ministry has recently confirmed that it will provide DHBs with funding for local MQSPs beyond June 2015.

Purpose, objectives and methods of the evaluation

The purpose of this evaluation is to provide evidence to inform decisions on sustaining and further improving maternity service quality and safety, and to inform the planning and delivery of other quality improvement initiatives. The objectives of the evaluation are to assess the progress, effectiveness and sustainability of the MQSP in contributing to the provision of safer and better quality maternity care for women, babies and their whānau.

The evaluation was informed by: a review of MQSP documents, including the annual reports produced by each DHB; interviews with 13 key stakeholders of national organisations; a focus group with the National Maternity Monitoring Group (NMMG); an online survey of 66 respondents in key positions within DHBs; individual or small group interviews with 136 stakeholders at five case study DHBs; a workshop with MQSP consumer representatives; and two workshops with an Expert Advisory Group and other key stakeholders. Evidence was collected against three key evaluation questions:

1. How much of a difference are local MQSPs making?
2. To what extent are national service improvement tools, structures and support contributing to changes in local maternity quality and safety?
3. How sustainable are the local MQSP programmes and activities?

Findings and conclusions

The context for the MQSP has played a critical role in determining how and how well DHBs have implemented local programmes. This includes the community context (e.g. geography, demographic profile and population health status), the DHB context (e.g. organisational, funding and workforce issues, maternity facility issues and recent maternity services issues), as well as the national and local leadership of the programme and the response of local maternity service providers.

How much of a difference are local MQSPs making?

There has been differential progress in the implementation of local MQSPs

Some DHBs (including one of the five case study DHBs) appear to have made very little progress and it is difficult to see what has been achieved with the funding.

The majority of DHBs (including three of the five case study DHBs) have established a quality and safety programme to some degree, where the funding has supported a dedicated quality role, there is a multi-disciplinary governance structure, projects have been implemented that have led to some improvements, there are processes for engaging with consumers, and data is being utilised to drive planning and improvement projects.

Some DHBs (including one of the case study DHBs) appear to have progressed further. These DHBs have a high degree of engagement with community providers, involve consumers in programme governance and on specific projects and this involvement is making a difference, and are beginning to see meaningful improvement in the quality of service delivery and outcomes.

There is variation in the scope of maternity quality activities

The MQSP has a clinical focus in some DHBs, others have taken a population health approach and some have both.

Most DHBs reported an expansion in the scope of their maternity quality and safety activities, with the majority of programmes having mechanisms for looking beyond the hospital to the primary and community sector, and establishing processes for consumer engagement.

The MQSP operates as a programme in many DHBs; however in others it has essentially been implemented as a series of projects that do not clearly sit under a broader programme.

The MQSP has increased the visibility of maternity quality activities

The number of maternity quality and safety activities implemented as a result of the MQSP, and the large number of people participating in these activities, has helped to raise the profile of maternity quality and safety.

A significant number of clinical quality improvement activities have been delivered

The vast majority of DHBs reported an increase in clinical quality and safety activities as a result of the MQSP. The MQSP was able to build on existing activities in some DHBs and '*take them to the next level*' by broadening their scope or reach. The more common activities include clinical audits (e.g. of postpartum haemorrhage (PPH), diabetes screening, induction of labour and caesarean section), case review meetings of complicated cases (e.g. trigger tool meetings), establishing and revising clinical guidelines, and improving documentation and coding.

Midwives, from DHB facilities and from the community sector, are more likely than other professionals to participate in maternity quality activities. Several activities are reaching hospital specialists, but to a significantly lesser degree, professionals in general practice and primary care.

The MQSP is beginning to have an impact on clinical practice and maternity outcomes

Clinical quality improvement activities, implemented or strengthened as a result of the MQSP, are beginning to have positive results. There is evidence of changes in practices, changes in attitudes and behaviours and of improved outcomes, including improvements in early registration with an LMC, reduced times between induction of labour and delivery, and reduced PPH rates. There is also evidence of quality improvement activities having had no impact on clinical practice.

MQSP governance groups have achieved wide membership but need to strengthen engagement

DHBs have established, or in many cases extended existing, governance group structures to oversee the implementation of the MQSP. With the exception of one of the five DHB case studies where the governance group is currently inactive, there is widespread membership of these groups, including from many health professional disciplines, from hospital and community-based services, and from Māori health. The main gaps in membership are consumer members and members from general practice. Leadership appears to be critical to the success of governance groups, with most being led by a clinical director with strong support from their MQSP coordinator.

While membership of governance groups is strong, there is a need to strengthen participation in meetings. Stakeholders referred to the absence of specialists, including paediatricians, anaesthetists and obstetricians.

Progress has been made in bringing together practitioners but this has a lot to do with existing relationships

There is considerable variation in the effectiveness of clinical networking across sectors and disciplines. Overall, there has been some improvement in clinical networking and sector engagement, however, existing relationships and factors outside the direct influence of the MQSP seem to be the key determinants of progress in this area.

There has been very limited engagement of GPs in the MQSP, other than through projects targeting early registration with an LMC. Greater consideration is needed in how to increase GP involvement in the programme, particularly as many maternity quality activities would appear to be relevant to primary care.

There is room for improvement in processes to engage with consumers

There are multiple ways that consumers can be engaged in local MQSPs and no single way would appear to meet all needs. Therefore it is difficult to prescribe a 'one size fits all' model for consumer engagement. Most MQSPs have focused on consumer engagement at a governance level, and many DHBs are also considering a wider spectrum of consumer engagement (e.g. on project teams and through consumer feedback mechanisms). There is plenty of room for improvement in how MQSPs engage with consumers, and for learning from where it is working well. This includes improving ways of engaging with consumers who are less likely to have the skills to effectively engage yet represent those consumer populations who experience poorer health outcomes.

Local clinical data is being used to identify and understand issues and problems

There are substantial barriers to the effective use of local data to drive quality improvement activities, including problems with coding, accuracy, completeness, access and incompatible IT systems. Nevertheless, some DHBs are increasingly using data to identify potential quality issues, and then using more in-depth analysis and multi-disciplinary interpretation of datasets to understand the issue and as a basis for developing quality improvement activities.

MQSP coordinators are the lynchpin of the programme

The vast majority of DHBs have funded a person to coordinate or manage their local MQSP. Throughout this evaluation, the instrumental role that local coordinators play has been a consistent theme. Along with local clinical directors, coordinators are providing the local leadership needed to oversee and drive the MQSP.

It is critical to the success of the programme that coordinators have the respect of clinicians, have strong relationships with teams across the DHB, are closely connected with the hospital department responsible for maternity services and have strong leadership skills.

To what extent are national service improvement tools, structures and support contributing to changes in local maternity quality and safety?

National tools and guidelines are well-aligned with local MQSPs but are used and valued differently

The MQSP was rolled out following work at a national level to develop the New Zealand Maternity Standards, Maternity Clinical Indicators, revised Referral Guidelines, a first suite of national clinical guidelines and revised DHB-funded service specifications. The NMMG was also established concurrently. MQSP stakeholders are aware of these tools and guidelines and their relevance to the programme, although they are not used and valued equally. The value of having a national set of Maternity Clinical Indicators that *'gives you something to aim for'* is widely recognised. The NMMG is playing a key role in raising the profile of maternity quality and safety, particularly at a senior executive level, and many quality activities being implemented under the MQSP have been driven by the NMMG. DHBs find the correspondence from the NMMG quite demanding, but recognise its value.

How sustainable are the local MQSP programmes and activities?

The MQSP is not yet embedded as core business within DHBs

The majority of MQSPs are not yet embedded as core business within DHBs and, as a result, the evaluation evidence suggests that if ongoing support were not provided:

- the MQSP coordinator positions would be lost and responsibilities be dropped or tacked on to someone else's job
- many quality improvement initiatives would continue, but the momentum and scope of projects would be reduced

- some initiatives would be dropped
- there would be a reduction in inter-sectoral work
- improvements that have been made would plateau
- trust that has been built up across the sector would be lost
- quality initiatives would become opportunistic rather than planned.

The time that it has taken to embed the programme is compounded by other things going on within the sector, the lean resourcing environment, and the complex nature of the cultural and behavioural change that is required.

Sustainability would be enhanced by strong leadership, inter-sectoral collaboration and sharing of good practice

Strong MQSP leadership is critical at all levels of the programme, including from national agencies, DHB chief executives, and from midwifery and obstetric clinical leaders who can engage the wider service in the programme.

A real benefit of the MQSP has been its interdisciplinary focus and reach outside of the hospital context. This needs to be further extended through greater collaboration with primary and community based care at a national level, building the quality of engagement with community midwives and consumers, strengthening processes that engage with vulnerable women and their whānau, and bringing primary care, especially general practice, into local programmes.

Local MQSPs have largely developed their quality initiatives independently. Increasing opportunities to *'do once and share'* good practice would enhance the programme's outcomes and sustainability.

Recommendations

Overall, there has been considerable progress and success in the implementation of the MQSP. The programme has significant merit, and within the right set of circumstances is beginning to make a difference to the quality and safety of maternity services. However, in other circumstances, the value added by the MQSP is not yet apparent. In order to reinforce the overall direction of the MQSP, promote improvements to its ongoing implementation and to strengthen the sustainability of the programme, the evaluation recommends:

1. Strengthening multi-disciplinary leadership of the MQSP at all levels of the health system.
2. Extending the scope and value of sector engagement in the MQSP and in local maternity networks.
3. Requiring DHBs to show how they effectively engage with consumers and use information and expertise gained through this engagement.
4. Resourcing the MQSP.
5. Facilitating learning and sharing of practice across DHBs.

These recommendations are further unpacked in the evaluation report.

1. INTRODUCTION

The Ministry of Health (the Ministry) appointed *Allen + Clarke* to evaluate the progress and effectiveness of the Maternity Quality and Safety Programme (MQSP) and inform the Ministry on next steps for sustaining and further improving maternity service quality and safety.

The evaluation is intended to:

- assess how local and national activities have broadened the scope and visibility of maternity quality activities
- develop a body of knowledge to inform district health boards (DHBs) and the Ministry on the progress made by local MQSP activity
- assess the effectiveness of the national tools to inform delivery of maternity quality improvement activities and to support local MQSP activity
- identify what is working well (and what isn't) at a local level and how best to sustain and further improve the safety and quality of local maternity services
- identify the key elements that will support DHBs to ensure local MQSPs operate sustainably from July 2015
- collate and disseminate findings from the MQSP that can inform other quality improvement initiatives.

1.1. The Maternity Quality and Safety Programme

In 2009, the Government asked the Ministry of Health to pursue specific priority actions as part of its Maternity Quality Initiative. One of the priority actions was to develop a MQSP, to improve the quality and safety of maternity services.

The MQSP aims to:

- improve local maternity quality and safety
- improve national service improvement tools and support
- establish national priority setting for maternity monitoring and quality and safety
- broaden the scope and visibility of maternity quality activities.

The programme builds on existing review systems to drive a shift in maternity services to provide safer and better quality maternity care to women and their babies in line with the New Zealand Maternity Standards.

The MQSP involves both local and national components and was launched in late 2011, with roll out to all DHBs in early 2012. The overarching design of the MQSP and the national tools were developed and rolled out in partnership with the key professional Colleges, including:

- NZ College of Midwives (NZCOM)
- Royal New Zealand College of General Practitioners (RNZCGP)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

- New Zealand Society of Anaesthetists (NZSA)
- Paediatric Society of New Zealand.

The funding and operational support for local MQSPs has been provided by the Ministry of Health. Funding for DHBs to implement local MQSPs included a fixed amount for each DHB to support the salary of a person to manage and administer its MQSP activities (i.e. an MQSP coordinator or project manager), and a variable amount based on the number of births in each DHB region. The total funding for DHB MQSPs was \$10.7 million over the four-year period (2011/12–2014/15).

1.1.1. Local MQSPs

Local MQSPs are now in place in every DHB. These involve local midwifery and medical leaders (working across community and hospital-based maternity care) and consumers in locally defined maternity quality and safety governance and accountability structures, as well as in quality and safety working groups.

Local MQSPs are designed to coordinate multi-disciplinary participation in clinical quality improvement activities and increase sector and consumer engagement in DHB led maternity service improvement. MQSP teams are expected to collaboratively identify improvement priorities for maternity services at the DHB level. Priorities are expected to be identified through systematic clinical quality review of maternity services data and information, involvement of clinical leaders, consumer engagement and feedback, routine monitoring against the national data and New Zealand Maternity Clinical Indicators, and review and advice from the National Maternity Monitoring Group (NMMG).¹ Local MQSPs deliver and/or coordinate local service improvement activity in relation to identified priorities and are tasked to support DHBs to meet their obligations under the New Zealand Maternity Standards.

Six core components of local MQSPs are explored in the evaluation:

1. **Clinical quality improvement** – quality improvement activities, systems and mechanisms in maternity. MQSP is intended to broaden the scope and visibility of quality improvement, and be driven by multi-disciplinary clinical leaders to identify and put in place locally relevant clinical quality improvement initiatives.
2. **Governance and clinical leadership** – leaders in midwifery, primary care and obstetrics working together at a local DHB level in a way that builds the workforce and improves the quality and safety of maternity services for women and their babies. The MQSP requires DHBs to establish governance groups comprising hospital and community-based clinical leaders, and consumers, to: oversee and ensure coherence across quality and safety activities, support implementation of recommendations from national bodies, contribute to discussions, decisions and recommendations around local DHB maternity care, and to produce an annual report.
3. **Clinical networking / sector engagement** – local maternity networks that enable practitioners working in maternity services across community and hospital settings – including self-employed maternity practitioners – to be brought together via a coordinated network. These local networks are intended to provide a way to coordinate

¹ Annex B includes a description of the New Zealand Maternity Clinical Indicators, the National Maternity Monitoring Group and the New Zealand Maternity Standards.

multi-disciplinary participation in quality improvement initiatives, and support practitioners to work together to identify local priorities.

4. **Consumer engagement** – engagement with maternity consumers to inform the monitoring of maternity services, and the development of quality and safety activities by incorporating the perspectives of women who receive hospital and community-based maternity services. Consumer engagement is particularly important to ensuring maternity services are accessible and safe to all women, their babies and families/whānau, especially high-needs populations and people who have difficulty accessing the services they need.
5. **Data monitoring** – utilisation of national data for each DHB including, but not limited to, the Maternity Clinical Indicators. Data should be used in identifying areas for further investigation that DHBs should focus on in their local clinical reviews. DHBs are also expected to collect and monitor additional local data to report and monitor clinical activities and outcomes.
6. **Management and administration** – how DHBs coordinate and administer any infrastructure and system requirements to support local MQSPs in terms of governance, clinical leadership, communications and operations.

Local MQSPs received implementation funding from the Ministry for four years until June 2015, after which time they were expected to operate as business as usual. Recently, the Ministry announced extended funding for local MQSPs in recognition of their current state as identified in the interim evaluation report (February 2015).

1.1.2. National tools and support

Local activities are underpinned by national quality tools and support that guides maternity service provision. National quality tools and activities include:²

- the NMMG
- the New Zealand Maternity Standards
- the New Zealand Maternity Clinical Indicators
- the National Clinical Guidelines
- DHB-funded Maternity Service Specifications
- Referral Guidelines (Guidelines for Consultation with Obstetric and Related Medical Specialties)
- National Consumer Surveys
- Information system and data reporting improvements.

All national activity is expected to continue as business as usual after June 2015.

² See Annex B for further details on national tools.

1.2. Purpose of the evaluation

The purpose of the evaluation of the MQSP is to provide evidence:

1. To inform decisions on sustaining and further improving maternity service quality and safety.
2. To inform planning and delivery of other quality improvement initiatives.

The objective of this evaluation is to assess the progress, effectiveness and sustainability of the MQSP in contributing to the provision of safer and better quality maternity care for women, babies and their whānau, including services that:

- are nationally consistent
- are accessible and comprehensive
- promote equity
- maximise impact
- support a woman-centred approach.

The maternity care system is complex and the evaluation is focused on the MQSP rather than the maternity system as a whole. The evaluation recognises that the programme is in its early stages of development and focuses on assessing implementation processes and outputs rather than outcomes which could be expected over the longer term.

The evaluation is based around three **key evaluation questions** (KEQs):

1. How much of a difference are local MQSPs making?
2. To what extent are national service improvement tools, structures and support contributing to changes in local maternity quality and safety?
3. How sustainable are the local MQSP programmes and activities?

1.3. This report

The findings in this report are structured around the three KEQs. The findings focus on evidence collected through in-depth case studies at five DHBs. These build on findings from key stakeholder interviews and an online survey presented in an interim evaluation report in February 2015.

2. METHODOLOGY

2.1. Evaluation approach

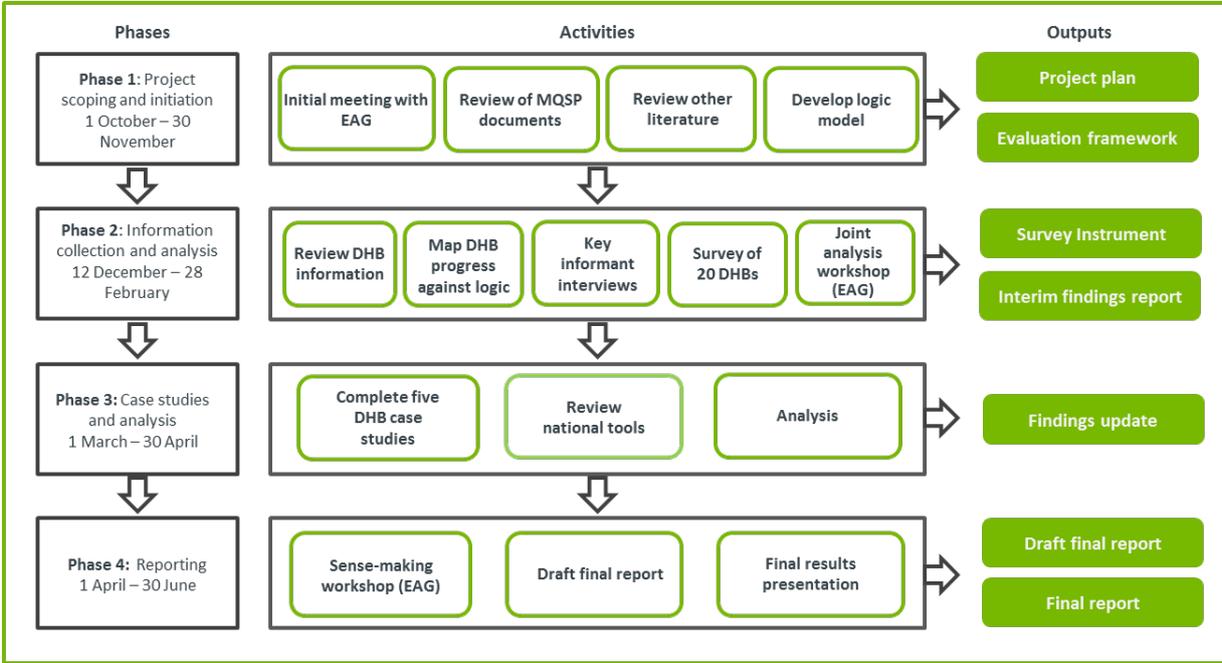
The evaluation took a formative approach to examining the progress, effectiveness and sustainability of the MQSP. The MQSP is in its early stages of implementation, and formative evaluation recognises that the programme is still developing and evolving.

The evaluation documented and analysed what happened during the implementation of the MQSP (2012–2015), and is intended to provide an understanding of how the national and local programmes operate and what factors influence their effectiveness and sustainability. As the MQSP has only been operational for a short time, the evaluation questions focused on implementation processes and it was not feasible to fully analyse the outcomes and impacts of the MQSP. However, where evaluation participants were able to identify short term impacts, these are noted.

Evaluative evidence was collected and analysed for each of the KEQs and at both a national programme level and for each of the six components of local programmes identified in section 1.1.1. Multiple sources of information and methods were used to answer the questions (see section 2.2).

The evaluation was implemented over four phases from October 2014 to June 2015, as shown in Figure 1. There was a need for the evaluation to inform the decision making around the future of the programme before this final report, and an interim report was produced after Phase 2 for this purpose. Findings of the interim report have been incorporated into this final report.

Figure 1: Evaluation phases, activities and outputs



2.2. Information sources and methods

The primary methods of data collection that were undertaken as part of this evaluation, as well as the number and types of information sources, are summarised in Table 1 below. Table 1 also includes how the data were analysed.

Table 1: Main methods and analysis used in the evaluation

Method	Information sources	Analysis
Document review	Maternity services specification Maternity Action Plan Report on Maternity MQSP documents (guidance, presentations, progress reports) DHB MQSP documents (strategic plans, annual reports) National tools (NMMG reports, Maternity Standards, Consumer Survey)	Information reviewed for relevant themes to identify baseline situation (what maternity quality and safety looked like prior to the MQSP), and to identify progress made by DHBs
Key stakeholder interviews	Ministry of Health (4) Perinatal and Maternity Mortality Review Committee, (PMMRC) (1) RANZCOG (1) NZCOM (2) Paediatric Society of New Zealand (1) RNZCGP (2) Nga Maia O Aotearoa Me Te Wai Pounamu (1) NMMG (9)	Data collected and analysed against the three KEQs Notes summarised into themes and then analysed across all interviews as an evaluation team group exercise
Online survey	Targeted staff in all DHBs and NZCOM Regional Chairs (66 respondents)	Data cleaned, open-ended questions coded into themes Frequency analysis for each question and filtering and cross-tabulations on specific questions
Case study interviews, observations and document review	Health professionals and consumer representatives within five DHB regions: <ul style="list-style-type: none"> Northland (38) Waitemata (34) Waikato (34) Wairarapa (14) Southern (16) MQSP strategic plans and annual reports, correspondence with NMMG and other documents related to local quality improvement activities	Documents analysed to describe context for each case study area and reviewed to identify main themes Interview data collected and analysed against three KEQs Notes summarised into themes and then analysed for each DHB (by team members who undertook the data collection) and across the five case studies (as an evaluation team group exercise)

Method	Information sources	Analysis
Joint analysis workshops	Two workshops with 11 members of an Expert Advisory Group and other midwifery, DHB and community representatives ³	Discussions focused on main emerging themes from the evaluation findings and identification of their significance to the MQSP Notes from these workshop discussions brought into final synthesis process
Discussion at Consumer Forum	23 consumer representatives and representatives from the Ministry and the Health Quality and Safety Commission (HQSC)	As above

Between 10 and 15 other professional bodies and consumer organisations were invited to participate in the evaluation. In response, one consumer organisation participated in an interview while two others provided perspectives through written responses.

2.3. Strengths and limitations

The main strengths of the evaluation approach and methodology are that it captures both the overall progress of the MQSP across all DHBs and, through in-depth case studies, drills down to collect context-rich information on how well the programme is being implemented and what factors are supporting/hindering effective implementation. The evaluation methods also achieved a high level of participation, with over 250 stakeholders engaged through various means.

The main limitations of the evaluation are:

- The findings suggest that the effectiveness of the MQSP is very context-dependent. This limits the ability to generalise the findings from the five DHB case studies.
- The timing of the evaluation (approximately three years since the MQSP was first rolled out across DHBs) limits the ability to capture evidence of outcomes and impacts on women and babies over the longer term.
- It is difficult to isolate the difference that the investment in DHB MQSPs has made from national maternity quality and safety activities (e.g. the New Zealand Maternity Standards and the Maternity Clinical Indicators) and from existing local level activities aimed at improving maternity quality and safety.
- Finally, the design of the evaluation meant that we did not speak to many maternity service consumers, other than MQSP consumer representatives.

³ The Expert Advisory Group included members from the Ministry of Health, NMMG, HQSC, NZCOM, RANZCOG, Paediatric Society, and two DHB MQSP coordinators and two MQSP consumer members.

3. HOW MUCH OF A DIFFERENCE ARE LOCAL MQSPS MAKING?

This section provides an overview of the progress, scope and visibility of local MQSPs, before looking in more detail at the effectiveness of the six core MQSP components.

3.1. There has been differential progress in implementing local MQSPs

Local MQSPs have made progress in the six key areas of the national programme, however, some have made more progress than others. Table 2, below, summarises what maternity quality and safety looked like in DHBs prior to the MQSP, and what it generally looks like now that the MQSP is being implemented.

Table 2: Progress in implementing the MQSP

Component	Prior to the MQSP	Since the MQSP rolled out
Clinical quality improvement	<p>Tended to be reactionary with most quality improvement activities taking place following serious and sentinel events</p> <p>Had some meetings, and undertook ad hoc multi-disciplinary reviews and clinical audits</p> <p>Some educational sessions for community and hospital midwives were organised mostly to meet quality assurance requirements for annual practising certificates and access agreements</p>	<p>Quality improvement often driven by data and/or multi-disciplinary reviews or audits</p> <p>Significant amount of quality improvement activity underway and wide participation in these activities</p> <p>Little understanding around how quality improvement would fit into business as usual</p>
Governance and clinical leadership	<p>Only a few larger DHBs had specific maternity governance and leadership structures</p> <p>Consumers and non-hospital staff were often not included in governance structures</p>	<p>All DHBs have set up governance and clinical leadership structures; most meet regularly although not all are currently active</p> <p>Governance groups vary in size, with most including hospital, community-based members and consumer members</p>

Component	Prior to the MQSP	Since the MQSP rolled out
Clinical networking / sector engagement	<p>There were weak networks in many DHBs between hospital and community-based midwives</p> <p>A few DHBs had strong midwifery networks</p> <p>Multi-disciplinary engagement on quality issues between midwives and other clinicians such as obstetricians and GPs was often weak</p> <p>Engagement often only occurred as a result of clinical audits and reviews</p>	<p>Midwifery networks and multi-disciplinary networks have improved, to some extent, with more active and respected participation in quality improvement activities</p> <p>Progress in strengthening networks has been variable and largely reflects the strength of existing networks</p> <p>Some DHBs are extending networks through creating pathways of care, for example, in maternal mental health or for vulnerable women and whānau⁴</p> <p>GPs remain largely absent from most clinical networks around maternity quality</p>
Consumer engagement	<p>Consumers were engaged through consumer surveys and complaints processes</p> <p>There were no consumer representatives for maternity quality improvement</p> <p>Consumer representatives were sometimes engaged on specific projects, such as new builds or projects targeting smoking cessation</p>	<p>In addition to surveys and complaints processes, most DHBs have consumer members on MQSP governance groups</p> <p>A national consumer network has been established and two consumer forums held</p> <p>Some DHBs have found consumer engagement problematic and have not been able to fill or retain consumer member positions – and some consumers, particularly those with strong opinions, have felt excluded</p>
Management and administration	<p>Quality and safety mostly sat within wider DHB quality improvement teams, with limited dedicated resource within maternity services</p> <p>A few DHBs did have dedicated personnel who were largely involved in surveys and complaints, and updating guidelines and policies</p>	<p>All DHBs have invested in personnel to manage and administer local MQSPs</p> <p>Most DHBs have established dedicated roles (e.g. MQSP coordinators) while others have extended salary for roles associated with quality improvement</p> <p>The management and administration of MQSPs generally sits within maternity or women's health; although in at least one DHB it has sat within Planning and Funding</p>

⁴ Women and whānau who are 'vulnerable' are those who are most at risk of adverse outcomes. For further information see: Ministry of Justice. 2010. *Who is vulnerable or hard-to-reach in the provision of maternity, Well Child and early parenting support services?*

Component	Prior to the MQSP	Since the MQSP rolled out
Data monitoring	<p>Data was collected by DHBs and sent to the Ministry of Health to meet specific contract requirements – local engagement in these processes was limited</p> <p>When DHBs did collect data to analyse for clinical quality improvement purposes, it was normally as a result of reviews and audits of serious and sentinel events</p> <p>Three DHBs produced regular annual maternity reports</p>	<p>Some DHBs have implemented new tools such as dashboards to make data more visible</p> <p>Data is commonly accessed and interpreted as part of quality improvement activities such as case reviews</p> <p>There has been differential progress in the extent to which local data is communicated with local stakeholders</p> <p>Most DHBs produce an annual MQSP report</p> <p>Data quality and trust in the data has improved</p>

The Interim Evaluation Report (February 2015) noted that progress in implementing the MQSP had been slower than expected. The progress of the five case study DHBs has been variable.

One DHB has made very little progress in implementing its MQSP, despite being a pilot site for the programme. The programme has been implemented within a very complex operational context and has struggled to recruit and retain its MQSP coordinator. The MQSP governance group met five times between January and August 2014 but has not met since. Within this difficult context, the MQSP has achieved very little, has poor buy-in from clinical leaders and the extent of support from the DHB is unclear. In terms of the Ministry's draft framework for ongoing support (see Annex A), this DHB is clearly at the 'emerging' level.

At the other end of the implementation spectrum, another DHB has been able to successfully layer its MQSP over an existing pilot programme and has made consistent progress across all programme components. The scope of this DHB's quality improvement activities is broad, including improving clinical practice, sector engagement and consumer engagement, and it has been able to closely align activities with wider initiatives relevant to the maternity pathway. Work across these components is beginning to make a difference to the quality of service delivery and outcomes. There is still room for progress in a number of areas, including strengthening midwifery networks and implementing change as a result of quality improvement activities. Many processes are now embedded in the DHB and there is confidence that ongoing improvements will be realised. This DHB has begun to plan for the future sustainability of the programme, and the majority of quality activities would likely continue without the Ministry's future support. As a result, this DHB probably sits at the 'excelling' level in the Ministry's draft framework.

The remaining three case study DHBs sit between these two extremes. They have clearly made progress in implementing their MQSPs, but they have not made significant plans for the future and many of their quality improvement activities would stop without ongoing support from the Ministry. The progress of each of these DHBs differs, both in comparison to each other and across the different components of the MQSP. All have made good progress in strengthening multi-disciplinary governance and clinical leadership of maternity quality and safety, and have established dedicated MQSP roles to manage and drive the programme. Progress in sector and consumer engagement has been more variable, with some struggling to break down barriers

between hospital and community-based practice and to maintain consumer engagement roles. A number of quality improvement activities implemented by these DHBs are well-embedded within core practice, but the programme as a whole remains vulnerable to wider DHB resourcing pressures. These three DHBs probably sit within the 'established' level of the Ministry's draft framework.

3.2. There is variation in the scope of maternity quality activities

3.2.1. Scope varies between a clinical focus and a population health focus

There is a wide scope of quality activities being delivered under the MQSP. Some MQSPs have taken a strongly clinical approach, others are more population health based, while others have developed as blended programmes. Clinically focused programmes have focused on the individual woman and her whānau and their clinical encounters within their maternity care experience. Quality activities include reviewing clinical data and case reviews and clinical audits. MQSPs that have taken a population health approach have focused more broadly on their community's needs and on subgroups within the community. These MQSPs have used population needs assessments, including assessments of disparities between population groups, and a focus on preventative measures such as promoting smokefree, safe sleep, nutrition during pregnancy and breastfeeding.

Table 3, below, shows the defining characteristics of clinical and population health perspectives. While we would not describe individual local MQSPs as either fully clinical or fully population health based in their approach, a number of local programmes do feature many of the characteristics of either a clinical or population health model. For example, in one case study DHB the regional public health unit undertook a comprehensive maternity health needs assessment including an inequalities analysis that was used early on by the MQSP. This programme has a strong interface with the public health team and its quality activities are largely driven by national agendas and targets concerning immunisation, smokefree and safe sleep. Some evaluation participants at this DHB questioned how well the population health focus translated to changes at the maternity service level: *'It is hard to see what's coming through at a floor level'*. By contrast, another case study DHB's programme has a strong clinical focus with quality activities driven by individual case reviews of clinical data and practices, and also a focus on updating clinical guidelines and building clinical pathways of care. This programme has achieved strong clinical ownership.

To some degree, the focus has been determined by the skills and experience of local MQSP coordinators (e.g. whether they have a clinical or public health background). Such a 'strengths-based' approach has some merit, particularly for the early stages of the programme when it is important to 'get some runs on the board' which is more likely to happen in those areas you are strongest in. The needs of DHBs are also likely to vary with one evaluation participant noting that *'the programme is only three years old and still in its infancy; for some DHBs knowing who their population are and what the needs of their population are is still a struggle'*.

Table 3: Clinical and population health perspectives⁵

	Clinical	Population health
Focus	Individual patient, clinical consultation and treatment, quality of individual care	Whole population or population groups, health and prevention outcomes, broader determinants of health
Evidence-based practice	Aim to achieve best management/treatment and clinical outcomes for individual patients	Aim to achieve best outcomes for whole population (cost-effectiveness) and to reduce inequalities in health
Participation	Patient-focused care, patient self-management	Community participation (real), accessibility and uptake of health services and public health interventions
Ethics and values	Professional integrity, patient autonomy, benefit and confidentiality	Equity, social justice, reducing inequalities
Collaboration	Multi-disciplinary teams	Intersectoral collaboration
Advocacy	For best care/treatment for individual patient	For health of whole population/communities and disadvantaged groups
Quality focus, monitoring and evaluation	Individual professional practice and patient outcomes – continuing professional development, audit and clinical databases	Population level outcomes, disparities between population groups

Participants in the evaluation workshops appeared to agree on the need for programmes to have both a clinical and a population health focus in each DHB, and noted that such a balance is needed in order to comply with the New Zealand Maternity Standards. This suggests the need for a wide range of activities, with the flexibility for local MQSPs to respond to national and regional population health priorities as well as to target quality initiatives that respond to the clinical needs of individual women and their whānau.

The focus of MQSPs has the potential to impact on multi-disciplinary and intersectoral engagement. Clinical engagement in the MQSP is certainly greater in the DHB that has a stronger clinical focus than a population health focused programme. Evidence about the impact on engagement with consumers and practitioners is less clear, but it is probably reasonable to assume that the type and level of engagement is likely to be influenced by a programme’s focus. For example, consumers might be expected to have a reasonable understanding of clinical practice if they are to effectively engage in a clinically focused quality and safety programme.

⁵ Source: Edwards, R. ‘The concepts and values of the population perspective’ for Vision 2020 NZ ‘Population Eye Health’ workshop 2009.

3.2.2. Many MQSPs are beginning to reach beyond hospital walls

As suggested in Table 2, the scope of maternity and safety activities has, for many DHBs, expanded out from the main hospital into other secondary and primary units, and into the community and social sectors. This is occurring at a formal governance level, including through consumer engagement, but also as part of the implementation of quality improvement activities (e.g. running case review processes in rural primary units), the development of pathways of care (e.g. for vulnerable women and for maternal mental health) and in communication and health promotion activities (e.g. around early registration with an LMC and sharing information on quality initiatives).

There is, however, a need to extend the scope of MQSPs through building stronger connections with rural and remote providers, community providers such as PHOs, GPs, Māori health providers, and with existing programmes in the community such as Whānau Ora and Well Child/Tamariki Ora. The evaluation team heard about programmes in the community targeting improved maternity outcomes (e.g. a PHO-based programme) that do not appear to be connected up with the MQSP.

Sector networking and engagement is discussed in more detail in section 3.7 and consumer engagement in section 3.8.

3.2.3. Some MQSPs are functioning as a series of standalone projects

In some DHBs the MQSP functions as a coherent programme, with a clear framework and programme administration. However, in other DHBs the programme is essentially supporting the delivery of a series of projects that are not well-aligned with each other and do not appear to sit within a broader programme structure. In one case study DHB this was done deliberately, on the basis that it would be simpler to establish, embed and sustain single projects than it would be to embed a whole programme of work. This approach was illustrative of the low expectations that this DHB had that the programme would be sustained and continue beyond June 2015.

There is similar variation in the extent to which the MQSP is functionally integrated with other initiatives in the DHB and community. In those DHBs with more integrated programmes, MQSP activities sit alongside and support other initiatives such as existing morbidity and mortality (M+M) review processes and programmes that target vulnerable families. In other DHBs the MQSP sits in a bubble as a collection of distinct projects and quality improvement activities; information is shared with teams working on other initiatives but there is a lack of coordinated and joined-up delivery. As a result, these programmes do not appear to be making as big an impact as they could.

3.3. The MQSP has increased the visibility of maternity quality activities

The MQSP has, including in all but one of the five case study DHBs, helped to raise the profile of maternity quality and safety. Many stakeholders talked about the greater focus on quality and safety, the momentum that has been built up, the follow through to practice and the visibility of this both 'up the line' and 'on the shop floor'. This is by no means universal and some MQSPs have achieved greater visibility in some areas (e.g. across DHB middle management) than they have on the shop floor or in the community.

The increased visibility of maternity quality activities is largely due to:

- The significant number of maternity quality activities implemented under the programme, and the large number of people participating in these activities (see section 3.4).
- Sharing and communication of information and data related to maternity quality through the MQSP annual reports, use of data dashboards showing performance against key maternity indicators, dissemination of minutes from governance group meetings and lessons from case review meetings, and specific communication tools (see box 1).
- Regular direct reporting from MQSP governance groups to DHB clinical governance boards, and/or to the DHB Board on progress against key indicators, what this means and what was happening as a result. This is particularly the case where there is a clinical leader who sits on the MQSP governance board, the clinical governance group covering maternity services, and on the DHB clinical governance group, as is the case in one case study DHB:

'I think we have set a standard for the DHB that has been missed in other places before this programme The DHB has a clinical governance group ... and so it was looking to go, 'well who is reporting to us?', looking down the organisation ... and we were about the only service that had a governance group that could report up ... other services are beginning to follow a similar model ... so we were a bit of a trail blazer in that respect'.

- The profile associated with attaching a position (MQSP coordinator) and other human resource (funding for consumer representatives, governance group chair, etc) to the programme.
- The national profile of maternity quality and safety built through the Maternity Standards, Maternity Clinical Indicators and the NMMG. The MQSP Annual Report process and the resultant correspondence to chief executives from the NMMG was noted by a number of stakeholders as key to the profile of maternity quality, although this is dependent on *'where the Annual Report and NMMG letters land in the pile on the CEs desk, as well as the expectations placed by the Minister [of Health] on the CE about what to do with it'*. Several stakeholders noted that other services are envious about the profile achieved for maternity quality as a result of having national standards, indicators and monitoring functions: *'we need to have the same thing in paediatrics'*.

A number of evaluation participants spoke about the lack of visibility or promotion of the MQSP, as a programme, at a national level. They felt that the only thing that makes it a programme is *'some money with a monthly teleconference, an annual consumer forum and some templates'* and noted a lack of information about the programme on the Ministry's, HQSC's and Health Improvement and Innovation Resource Centre's (HIIRC) websites. More national level visibility would, in one person's words, *'give us something concrete to refer to'*.

Box 1: A maternity quality newsletter

One DHB publishes a monthly *Maternity Quality News* which is emailed monthly to all community midwives⁶, doctors in maternity, educators, and core midwives, and a hard copy is posted in the clinical areas on Quality noticeboards, and also on the Clinical e-decision making page on the DHB's Intranet.

This one page newsletter features a monthly focus topic, such as correct labelling of blood samples, and associated recommendations to improve practice, learning points from PMMRC and case review meetings, and provides a schedule for future meetings.

During the evaluation case study, many stakeholders spoke positively about the newsletter, valuing it both as a regular reminder and for the guidance and recommendations it made, including in leading readers to more detailed guidance through hyperlinks:

'Fantastic, one page, cohesive, topic in one paragraph and very readable'.

'Amazing. Enables you to look across everything that's going on. Relevant content. It's current. It doesn't talk at you. It links to outcomes'.

'... really good ... focus on a policy or guideline ... on the odd occasion the blood labelling disappears into naughtiness ... it pops back up on there, you're reminded, it gets you back in that groove It's practical'.

	Total	North Shore	Waikare
132 charts were examined (17 West and 65 North)			
Admission CTG	81 (61%)	43 (66%)	38 (54%)
Complied with guideline	48 (59%)	20 (30%)	28 (42%)
Documented indication	38 (47%)	20	18

	Total	North Shore	Waikare
81% women had an admission CTG. Two thirds of women who gave birth at North and just over half at West had an admission CTG. Only one third (30%) of all admission CTGs complied with WDCSB guidelines. The indication for performing the CTG was documented in 47% cases (evidence was hard to find), advised consent was not often explicit in the charts we audited (but may have been in LMCC Care Plan that was not placed into her current hospital notes).			
CTG completed - not indicated	30 (23%)	20 (24%)	10 (14%)
CTG indicated - not performed*	14 (22%)	3 (5%)	11 (16%)

Review	Date	Time
Case review West	Thu Jun 19	@ 08:30
Case review North	Mon Jun 23	@ 13:00
Perinatal West	Thu Jun 5	@ 09:00
Perinatal North	Mon Jun 9	@ 13:00

3.4. A significant number of clinical quality improvement activities have been delivered

3.4.1. There is a lot of clinical quality and safety activity happening

In the interim evaluation report we noted that the vast majority (79 percent) of survey respondents rated their programme's performance in terms of the development of new quality and safety activities as 'good' or 'excellent'. In the evaluation case studies, it is evident that the MQSP has enabled DHBs to develop new clinical quality improvement activities and take existing activities 'to the next level' through broadening the scope and intensity of activities and their reach in terms of increasing multi-disciplinary engagement.

⁶ Throughout this report we have used the term 'community midwife' to refer to self-employed midwives working as lead maternity carers in the community. We prefer this rather than referring to them as 'lead maternity carer' (LMC) which is a contractual term that may refer to midwives, GPs or obstetricians.

Examples of the range of clinical quality improvements activities that have either been initiated or built on as a result of the MQSP are shown in box 2.

Box 2: Clinical quality improvement activities in case study MQSPs

- **Establishing or updating local guidelines, policies and procedures:** This includes, for example, guidelines on PPH, blood transfusion after caesarean and transfer of care. One DHB has managed to get 75 percent of its guidelines updated and to establish a process for regular updating. While it already had a guidelines committee tasked with this, the MQSP coordinator has driven the updating process. Other DHBs have made less progress in this area; one reporting 73 out of 90 (80 percent) guidelines were out of date. The MQSP has supported the process of establishing new guidelines with stakeholders in one DHB appreciating the inclusive and robust processes:

'We all had a say in it ... not just emailing but discussing ... we were able to pull the [existing] guidelines apart ... not so [hospital]-centric ... know each other's expectations and backstories and now feel more confident'.

- **Clinical audits:** Audits have been undertaken on a range of clinical areas, including PPH, diabetes screening, induction of labour, general anaesthetic, caesarean rates and pre-eclampsia. Many of these audits target areas which DHBs have identified as an outlier, nationally, and are often undertaken to test whether guidelines have been followed and whether existing guidelines are appropriate.
- **Establishing a pathway for maternal mental health:** Three case study DHBs have developed standard maternal mental health pathways and noted improvements as a result. These pathways are new and the focus has shifted to informing and training services and practitioners, including community midwives and PHOs.
- **Case reviews (including M+M reviews):** Two DHBs have extended on existing processes for undertaking M+M reviews of serious and sentinel events to develop processes for undertaking regular clinical case reviews of broader issues and risks identified through clinical indicators and trigger tools (see box 4). Additionally, M+M review meetings have become more inclusive with greater participation of clinicians (beyond clinical leaders), including those who operate out of the main hospital setting, and are more rigorous as a result.

Broader, non-clinical, quality improvement activities focus on preventative projects and health promotion activity around safe sleep, smokefree, nutrition during pregnancy and breastfeeding, including projects targeting vulnerable communities. Some specific examples are provided in box 3.

Box 3: Other quality improvement activities in case study MQSPs

- **Early registration:** Most MQSPs have recognised early registration with an LMC as low and developed responses to fit their local context. One DHB with low registration analysed its data to discover that early registration was lowest among teenagers and that it was not just a problem with its rural/remote communities. The DHB then surveyed its population on how they found an LMC, discovering that 25 percent of the population had no internet access. It ran a poster campaign which resulted in a shift in those registering in the third trimester to the second trimester, but it didn't make a significant difference in the rate of first trimester registrations. They are now embarking on a health promotion campaign targeting early registration, alcohol and drug free, smokefree and healthy eating, through a variety of media (bumper stickers, billboard and radio).

Clearly early registration has been a focus of DHBs for some time. Nevertheless, the MQSP has made a difference:

'Would we have done it without the MQSP? I think it would have been incredibly difficult to do. First question would be who would have done it? Everything prior to the MQSP probably landed in the lap of the Clinical Midwifery Director. One individual who already has professional oversight and a full portfolio. Without this resource and the programme of work, how would we have done it? Lots of letters going to PHOs and LMCs but so what? At least with this [the MQSP] we've had PHOs at the table, LMCs at the table, there's a clear rationale to why and how we're going to get measured, and it's an ongoing conversation...'

- **Antenatal education:** Two DHBs provided examples of projects targeting low engagement from Māori and Pasifika families in antenatal classes. One of these DHBs is looking to hold classes in a local marae to help target its Māori community. The Pasifika coordinator at another DHB has run workshops on early registration with a community midwife through Pasifika churches, a community fono to profile community midwives including the two Pasifika midwives, and has organised the delivery of Tapuaki antenatal parenting and pregnancy classes (six components over two weeks). While these initiatives are not directly a part of the MQSP, clear linkages are being established between the programme and these wider initiatives which impact on maternity quality and safety.
- **Health promotion:** One DHB runs Te Aka Oranga Waikawa Wahakura Wānanga (weaving wānanga) which focuses on teenage mothers. The weaving day entails weaving a wahakura⁷ and delivering subtle messages about smokefree, safe sleep, gentle mothering and an appreciation of Māori cultural traditions around parenting. The Māori families' coordinator has developed and run one wānanga and more are planned. Feedback includes a story from one young mother who came with her partner's mother with whom she had a poor relationship. By the day's end she described the experience as 'mending my own brokenness' and how she also found peace with her partner's mother through weaving.

⁷ A flax woven sleeping pod for new-borns and infants.

A case review approach implemented as part of one MQSP generated a lot of positive feedback from a variety of practitioners. The process is intensive and inclusive and appears to be contributing to a safe and effective learning environment. The approach is discussed in box 4, below, as it would appear to offer valuable lessons for similar activities in other DHBs.

Box 4: Case review process

The process is based around a trigger tool (TT), which comprises 29 triggers for clinical risk management. When a risk is 'triggered' the clinician completes a form which is reviewed by the MQSP coordinator. The coordinator then facilitates the review process, which involves a review of clinical notes and data for presentation and consideration at a case review meeting.

The case review meetings are held twice a week and last year reviewed 190 cases (they are expecting around 270 cases for the current year). Around eight to ten people attend the meetings, with good representation from core and community midwives and obstetricians, and less frequent attendance from paediatricians and anaesthetists. The case review meetings are held in the DHB's main hospital and, once a month, in the DHB's rural primary units.

Initially there was some resistance to the 'TT meetings' with practitioners reporting that they felt 'scared', 'hung up to dry', 'exposed' and 'judged'. The MQSP coordinator established ground rules to keep the process safe, such as ensuring respect, only one person talking at a time, focusing the discussion on the issues and not on the carer, anonymising the case, and ensuring the case is easily understood by the range of people there to review it. The main carer is encouraged to present their own cases, and the coordinator helps them to prepare for this by front-footing issues that are likely to come up and playing a devil's advocate role by asking tough questions before the meeting.

Participants now describe the TT meeting process as 'safe', 'supportive' and 'non-threatening', and as encouraging an 'atmosphere of collegial learning, compared with a defensive environment'. They still get involved in very robust discussions in the meetings and several clinicians spoke about making sure they get their documentation correct 'in case it ends up at a TT!'

The practice of taking the TT meetings out to rural units has helped 'bring us out of isolation' and get everyone 'on the same page':

'Bringing the TTs local is a big bonus. Lots of triggers are from transfers out of primary care so they're very relevant. Local midwives come in for the TT meetings so we get good networking on top. The format works well. It's not seen as a scrutiny of local practice It's been some time since education was brought to [town] It means there's no need to get back-up to attend external training It brings rural decision making to the fore. In absence [of having the meetings locally] I feel clinically isolated. It gives an insight into secondary care, keeps you on top of changes, latest policies and protocols ...'.

The process implemented for the TT meetings has had a flow-on effect on the existing M+M meetings, with several evaluation participants noting that these meetings are copying the format of the TT meetings and becoming safer and more effective learning exercises as a result.

The quality improvement activities that are being implemented seem to be relevant to both national and local needs. While some case study participants felt that their local MQSP had limited space for implementing activities that respond to local priorities because of the need to respond to national directives, the predominant view was that national and local priorities are not dissimilar:

'If you list national priorities and then compare DHB priorities there won't be a lot of difference'.

'They [referring to priorities set by the NMMG] may not have been all the priorities we would have chosen, but mostly align and are no brainers'.

Some local clinicians commented that the correspondence from the NMMG largely confirms what they already know are their local priorities. This is not surprising, given that many of the national priorities identified by the NMMG come from an analysis of MQSP annual reports. Other national priorities are driven by PMMRC's report, which are again based on what has been reported locally.

As indicated earlier in this report, progress across DHBs has not been even and there is still considerable room for improvement in all MQSPs. In one case study DHB there has been little focus on clinical quality improvement and while some audits have been undertaken, they are largely on an ad hoc basis. Potential improvements to clinical quality improvement activities include:

- Extending initiatives so that they are relevant to communities and services outside of the main urban centres (e.g. the pathways that have been established for maternal mental health in some DHBs have limited visibility in rural and remote areas).
- Giving greater attention to closing quality improvement cycles (i.e. taking action, changing practices and monitoring/reviewing these changes as a result of improvement activities).
- Bringing greater coherence and logic to the programme of clinical quality improvement activities, for example, case reviews leading to clinical audits, which in turn may result in updated guidelines and newly defined clinical pathways. There are examples of this happening, but also too many examples where one activity is happening independently of anything else.

3.4.2. A significant number of people are participating in these activities

It is important to appreciate the reach of many of the quality improvement activities taking place under the MQSP. As one evaluation participant put it: 'The fact that people are stopping and making time for quality improvement is a huge step'. Or as we discovered, the fact that over 250 people engaged with us on maternity quality and safety as part of this evaluation is not insignificant in itself. Most of these evaluation participants were able to talk about quality improvement activities that they have been involved in, and the number of participants and the regularity of participation has, in many cases, been impressive. The example of the trigger tools case review meetings in box 4, above, has eight to ten participants attending review meetings twice a week. Case review meetings at another DHB are less frequent, but attract up to 70 participants and usually 20 to 30. MQSP governance groups are also usually well attended (see section 3.6), with one group having 24 members.

In a previous evaluation of a continuous quality improvement initiative, *Allen + Clarke* noted the 'degree of enthusiasm and fervour among health workers for quality improvement' created by the initiative.⁸ This is also apparent in the evaluation of the MQSP, but it is certainly not universal. In one DHB community midwives felt very positive and on board with their local MQSP activities, while the core midwives were almost completely disengaged and disinterested. Other programmes have yet to achieve the level of multi-disciplinary participation that would demonstrate buy-in and enthusiasm, particularly among anaesthetists, paediatricians and GPs.

3.5. The MQSP is beginning to have an impact on clinical practice and maternity outcomes

Clinical quality improvement activities, implemented or strengthened as a result of the MQSP, are beginning to have positive results. All DHBs provided anecdotal evidence of changes in clinical practice. For example, several evaluation participants at three of the five case study DHBs noted that obstetricians are now less likely to accept caesareans as 'normal', questioning the need for them more than in the past and '*trying anything to avoid a caesarean*'. In one DHB this is particularly focused around trying to encourage vaginal birth after caesarean (VBAC). This focus on reducing caesarean rates and normalising VBAC is partly attributed to greater awareness of where their DHBs sat in relation to the national Maternity Clinical Indicators. Similarly, another DHB which has implemented a normal birthing project has seen delayed cord clamping normalised and cardiotocography (CTG) machines used only where need indicates: '*We no longer treat every woman like she needs to go on the CTG*'.

Though acknowledging it is too early to be certain about persistent outcome improvements, one DHB demonstrated a reduction in PPH from 23 in the 6 months prior to establishing a new local guideline on PPH, to 12 in the 6 months since the new guideline. Evaluation participants put this down to everyone knowing what to do and the transparency and visibility around the issue (PPH flowcharts are positioned above beds and the statistics are reported in the monthly data dashboards).

Two DHBs provided examples of how audit projects set up under the MQSP have led to reduced times between induction of labour and delivery. These projects involve reviews of clinical data, feedback from community midwives and complaint forms. As a result, Prostin is now administered earlier and one DHB could demonstrate that the time from coming in to the unit to going to the delivery suite has reduced by five hours. The MQSP has changed the whole induction of labour pathway and led to a new consensus policy. Another DHB, which has audited and developed a new guideline on induction of labour, has seen a reduction in its induction rate of three percent in one year which is, in the view of one stakeholder, '*a direct result of looking at it*'.

There is also evidence of quality improvement activities having had no impact on clinical practice. One core midwife commented that they have seen no changes in practice on the floor as a result of the MQSP and that people in the DHB did not see its high caesarean rate and low VBAC rate as a big deal. This highlights that change can be difficult and takes time, especially

⁸ Allen and Clarke 2013, *Evaluation of the Northern Territory Continuous Quality Improvement (CQI) Investment Strategy: Summary report*, Department of Health and Ageing, Canberra.

when dealing with behavioural change or changes that require approval of business cases within large institutions.

One DHB considered that improvements in its sudden unexplained death in infancy rate and breastfeeding statistics are indicative of the impact of health promotion programmes supported by the MQSP, such as the distribution of Pepi-Pods.

3.6. MQSP governance groups have achieved wide membership but need to strengthen engagement

All five case study MQSPs have governance groups in place to oversee their quality and safety activities and reporting. In some DHBs, this MQSP governance function has been added to an existing committee and helped bed in these processes, while others established a new group at the beginning of the programme. As discussed in section 3.1, one of these governance groups was inactive at the time of the case study visit and had not met since August 2014. The other groups meet regularly, generally either monthly or quarterly.

The governance groups have achieved widespread membership, and commonly include: community midwives, core midwives, primary facility managers (including non-government organisation birthing centres), consumer members, midwifery leaders, relevant specialists (obstetricians, anaesthetists and paediatricians), and representatives from the DHB's Māori, Planning and Funding, and Quality directorates. Three (of the five) MQSP case studies have GP or PHO representatives; however, they do not always attend the meetings. It is common for anaesthetists and paediatricians to also miss meetings or to only attend for part of a meeting. In terms of gaps in governance group membership, some MQSPs are still trying to get consumer members and most programmes feel the need for greater representation from GPs or PHOs, particularly in the absence of other forums for community midwives and primary care to interface. One MQSP in a highly multi-ethnic community would like to see more representation from its Asian community, either through Asian consumers or community midwives. Numerous stakeholders considered that the governance group that was inactive did not have adequate representation across its various sites, including across its two larger hospital facilities.

Meetings of governance groups cover updates on projects, discussion of audits and key learning from case reviews, discussion of new guidelines and protocols, feedback from facility managers, updates on any patient experience / consumer feedback results, any issues brought by consumer members, and reports from other groups/project (e.g. an update from the newborn hearing screening programme). One case study MQSP governance group regularly discusses external research requests as part of the DHB's ethics approval process. Some governance groups report up to the DHB clinical governance group and/or to the DHB Board.

Of the four active case study MQSP governance groups, most appear to function well; are well attended, organised and led; and members feel highly engaged and well informed. Critical success factors identified by the evaluation include:

- Governance groups have adequate representation from and visibility across DHB and community facilities and providers.
- All members, including consumers and community-based providers, are consulted on agenda items before the meeting and given an opportunity to add to the agenda (as

opposed to simply having a slot on the agenda where they can raise issues, or having no slot at all).

- Meetings are well structured, formatted and run efficiently (members are encouraged to attend next time!)
- All members feel included, listened to, respected and that their input is valued.
- Consumer members receive support, if needed, in preparation for meetings.
- There are no cost barriers to attending. The evaluation found that while all consumer members are paid for their attendance, some community midwives are not. For some community midwives this is not an issue; but for others it is, especially if they need to travel some distance to attend the meetings.
- Members are taking information that is discussed at the meetings back to their colleagues (as appropriate).
- There is strong leadership of the governance group and drive from the MQSP coordinator, and this is well-supported by clinical leaders.
- Meetings provide an environment that enables rigorous questioning and thorough discussion and, as a result, decision making is transparent.

Where these factors are not in place, there is evidence of low engagement in MQSP governance processes. Two particular examples of factors contributing to low engagement are:

- Several evaluation participants who sit on one governance group felt that, while there is useful discussion of information at the meetings, the information flow is one way only. They see the governance group as the DHB's mechanism for getting information down and out to the sector, as opposed to a forum that they can bring issues to. As a result, they reported that community midwives and providers are comparatively silent in the meetings and often do not show.
- Several evaluation participants also reported the need to improve processes for core and community midwife representatives to feed back issues discussed at the governance group meetings to their colleagues. While community midwife representatives often take issues back to their colleagues through interface meetings, these meetings are often not well attended. Some core midwives, reportedly, see their attendance as part of their job and not something that they need to be sharing with others.

3.7. Progress has been made in bringing together practitioners but it has a lot to do with existing relationships

3.7.1. Community midwives – hospital-based services

Ownership of the MQSP largely sits within DHBs maternity services. However, in some DHBs, the programme is being used effectively to facilitate the community midwife voice and to bring community and core midwifery together, in some cases breaking down 'them and us' situations. Overall, however, there is some way to go before there is joint community-hospital ownership of the programme and engagement between community midwives and hospital-based staff remains weak in a number of DHBs. A summary of the interface between community midwives and hospital-based services for the five case study MQSPs is included in box 5, below.

Box 5: Engagement between community midwives and hospital based services

- In one case study, the MQSP is predominantly a top-down programme and while community midwives are involved in it, their voice appears relatively weak. Some feel that the relationship between community and hospital services has deteriorated and described it as dire: *'If we [community midwives] have problems we put in complaints; if they [core staff] do they put in an incident form'*. Stakeholders did not attribute this to the MQSP and felt that there is a wider mind-set in the DHB whereby it sees itself as solely focused on secondary and tertiary care and sees primary care as *'not our business'*. There is a view that relationships with community-midwives have recently improved and there do appear to be efforts to engage with community midwives in the regions.
- In another case study, community midwives feel engaged and on-board with the MQSP and reported good relationship with obstetricians. However, core midwives are not engaged in the programme and are disengaged generally, feeling that the whole maternity unit revolved around the community midwives and that they *'got the short end of the stick'* and are only involved in providing fairly low level care. They feel *'deskilled'* as a result and there is a high level of disillusionment among the core midwifery team. There is a degree of tension between community and core midwives and limited sharing of information or care.
- Another MQSP capitalised on an existing strong midwifery network and the programme demonstrates strong communication between community midwives, core midwives and obstetricians. Community midwives described feeling *'safe'* in their practice and consider that the frequent MQSP quality improvement activities provide an opportunity to get together, contributing to *'interdisciplinary respect'* and a *'levelling'* of relationships with clinicians and consultants: *'It makes us feel valued, compared with what you always do is invisible and not quite right'*. The MQSP coordinator noted that there is still work to do to build these stronger networks with community midwives in regional areas.
- The situation in another MQSP is complex and relationships between community midwives and hospital-based services have strong historical contexts that differ across sites. Generally, there is tension between community midwives and the hospital core midwifery and obstetrics teams. For example, at one facility, very few core midwives attend a weekly meeting with doctors and community midwives, while no medical staff attended a recent meeting on communication. Bi-monthly access holders meetings (for community midwives) have, reportedly, turned into *'gripe sessions'* and it is lucky if one obstetrician attends. However, a variety of evaluation participants at this DHB did talk about these relationship as *'improving'*, especially on the floor.
- Evaluation participants in another MQSP spoke fairly positively about the communication and relationship across community and core midwives. A number considered that improvements in sector engagement are due to the MQSP and the coordinator, who having previously worked as both a core and community midwife, has helped to *'breach the gap between LMCs and the hospital'*. Community midwives reported that: *'You can talk to doctors like you couldn't before ... [because] now we're all referencing the same thing [referring to new guidelines and evidence resulting out of the MQSP]'*. This DHB acknowledged that there is still work to do to broaden ownership of the programme across a wider group of community midwives as they tended to get the same group of 8 to 12 midwives attending case review meetings, governance group meetings and midwifery forums. In particular the DHB recognises the need to bring its population of Asian midwives into the programme.

In summary, across the five case studies there has been some progress in bringing together community midwives and hospital-based staff. However, progress in some areas has been minimal and existing relationships and factors have played a significant part in the progress (or lack of), rather than the MQSP itself. These factors include historical relationships between community midwives and hospitals, issues surrounding workforce supply (e.g. relationships are generally better when there is not a shortage of midwives) and career progression, personality problems and financial problems. Information technology (IT) was often cited as another barrier to improving hospital-community networks, as DHB systems have limited accessibility outside of the base hospital.

3.7.2. Across other community services

Looking more broadly at networks between maternity services and other community-based services, and the engagement of these services in local MQSPs, there is evidence of strengthening networks but also significant gaps.

One of the key gaps is engagement of GPs where relationships tend to come down to individuals and there is a lack of more formal or structured ways to bring GPs into the MQSP network. As discussed, some MQSP governance groups have GP representation but they are not particularly engaged in the programme and it is not filtering through to other GPs. There are examples of where GPs, primary care and PHOs more broadly, have been involved in specific projects, such as projects targeting early LMC registration, and several stakeholders did talk about taking a step-wise approach to sector engagement and are planning to target GPs as part of the next step to strengthening local maternity networks.

Similarly to the community midwife-hospital interface, the historical context for the community midwife-GP interface seems to be a determining factor in GP engagement in the MQSP. Very few GPs take the role of lead maternity carer (the RNZCGP estimates it as less than 30 nationwide) and, as one stakeholder put it, *'the rift between LMCs and GPs runs deep'*. We certainly heard evidence of this and there appears to be an ongoing communication/information block across this interface. There were comments about delays in women enrolling with a community midwife despite having seen a GP to confirm pregnancy and also comments that midwives failed to notify GPs post-natally about the course of the pregnancy and birth and the health of women and their babies. These communication gaps are a concern for maternity quality and safety.

Several evaluation participants felt that the relationship with GPs has improved and that there is now less segregation: *'We're all getting better at showing our dirty laundry'*. There would appear to be a need and an opportunity to:

- Share examples of good practice of GP engagement in MQSP.
- Target GP involvement in relevant quality improvement activities, especially those involving community midwives, such as case reviews and in projects that target the care pathway.
- Lead by example at a national level through strengthening GP and college (RNZCGP) engagement in the MQSP, including through the NMMG.

A number of DHBs (three of the five case studies) have established systems for strengthening integration of care across hospital-based and community services, particularly targeting vulnerable women and their whānau. In one DHB a vulnerable women's group has been established as part of the MQSP but similar systems in the two other DHBs have developed out of other projects and are not directly attributable to the MQSP. However, given the focus on

providing wrap-around support and improving quality and safety, the MQSP has built strong links with these support systems. Box 6 provides an example of one of these services or networks targeting vulnerable families.

Box 6: Multi-disciplinary networks for vulnerable families

In one DHB, Te Aka Ora provides a multi-agency case management forum concerned for vulnerable families, including women with significant social issues that may affect a safe pregnancy. It involves midwives and doctors, and practitioners from mental health, community, alcohol and drug services, child, youth and family services and justice services. The forum meets three times a month to discuss and plan oversight of the women and families who have been referred by midwives and doctors. It has been running for three years and in that time has had increasing numbers of referrals, from 77 in 2012 to 187 in 2014. The forum focuses on alerting agencies, referring to agencies and resources such as pepi pods, and ongoing follow-up and monitoring. It aims to ensure that this vulnerable group of families has the right services offered to them. Cases are reviewed soon after birth, and are 'completed' once the forum is satisfied that the woman and baby are safe. This may be several months after birth.

There is evidence of engagement with other community-based services in local maternity networks, such as Well Child / Tamariki Ora providers, Māori health providers, antenatal educators, lactation consultants and smoking cessation providers. But many of these groups do not appear to be strongly networked in to local MQSPs, and we heard views that more needs to be done to use these networks to reach out to vulnerable women, such as Māori teenage mums. Greater outreach into primary and community-based care should consider:

- Strengthening linkages with initiatives that are already working in the community, such as those being delivered through Māori health providers and Whānau Ora workers that may target 'hard to reach' women and their whānau.
- Whether there is a role for MQSP consumer members in brokering greater coordination and collaboration with community-based initiatives.
- How public health teams (e.g. smoking cessation teams) can help facilitate access to community-based networks.
- The role social determinants of health play in maternity quality and safety (e.g. for late presenting or registering women) and, therefore, where there is an opportunity to strengthen social sector networks (e.g. with public health, schools, housing services, etc.).

3.7.3. Across hospital departments

As discussed earlier in this report, hospital-based clinicians from obstetrics, anaesthetics, paediatrics and mental health are engaged, to varying degrees, in MQSP quality improvement activities and governance roles. Collaborative working on maternity quality and safety across other departments, such as emergency, surgical and medical departments, is less apparent. Stakeholders in two case studies commented on the poor information sharing between the maternity unit and the emergency department (ED): *'ED is particular bad; they do not know anything about the maternity unit and the midwives have absolutely no communication with ED'*.

Others commented on the need to strengthen multi-disciplinary work with groups like paediatricians and dieticians with the growing importance of high risk consumers with obesity and diabetes.

MQSPs that cover more than one secondary unit have had mixed success. One programme has achieved strong representation, engagement and collaboration across its two secondary facilities, helped by their close proximity. Another programme is being implemented in two geographically distant hospitals, is perceived by a number of people to be focused on one of these facilities, and has struggled to get collaboration across the two. DHBs with rural or regional units have also had mixed success in bringing isolated teams into a collaborative network. Having the MQSP coordinator regularly visit regional units, take quality improvement activities out to these units, and facilitate regional staff involvement in other initiatives through video-conferencing are critical to establishing a collaborative relationship.

3.8. There is room for improvement in processes to engage with consumers

Consumer engagement in maternity quality and safety is occurring at a number of levels, including at governance, service, community and individual levels. The Ministry acknowledges that the original guidance around consumer engagement probably had an incorrect focus on engagement at a governance level only:

'It has become clear that engagement needs to include a broader focus; not just two consumer representatives on governance group'.

3.8.1. At the governance level

At the governance level, all five case study MQSPs have had consumer members or representatives on their governance board. However, this has not always worked well. In one DHB the MQSP coordinator initially sat on the governance group as a consumer representative and travelled to existing consumer forums and receive feedback which she would present at MQSP governance meetings. This was not considered effective and there is no longer consumer representation at the governance level in this MQSP. A second case study MQSP also has no current consumer representation at the governance level. Consumers had been engaged early in the programme but it had not worked out. Several evaluation participants reported that it had been difficult to maintain consumer involvement when the DHB was 'still finding its feet' on the programme and the governance function was not yet clear.

A third MQSP has two consumer members on its governance group but their influence appears limited. While they regularly attend the meetings and other members of the governance group find that the consumer members *'keep us on our toes ... make us feel more vulnerable and honest'*, the consumer members themselves feel unsupported and largely ineffective. These consumer members were recruited because of their strong community connections, but find the governance role difficult, partly due to the jargon in what is a clinically focused programme. Other barriers to their effective engagement include:

- The meetings can be time consuming and problematic for working consumers.
- They are unsure of their roles and the expectations on them as members of the governance group.

- While they get paid for their role, one member has to make up for the time that she takes off work to attend meetings.
- They did not feel well-inducted/orientated, do not feel well-supported between meetings, or feel that they have the opportunity to be debriefed after meetings.
- While there is always slot on the agenda for them to raise any issues, they do not feel able to add items to the agenda before it is sent out.

Consumer representation at the governance level at the two remaining case study MQSPs is functioning well, with the consumers reportedly well-engaged and feeling that they are making a difference. One programme's consumer representation stands out and may offer valuable lessons for other DHBs, see box 7. It contrasts with the previous case above on a number of levels; not least because the consumer members were appointed based on their skills and knowledge in maternity consumer reviews, as opposed to their strong community connections.

Box 7: Consumer membership of governance groups

The two consumer members on an MQSP governance board had been in the role for 18 months. They were shoulder-tapped for the role as they held existing roles as consumer reviewers for the NZCOM (in one case for 6 to 8 years) and the MQSP coordinator knew they were up to speed on women's health, used to challenging and not afraid to ask tough questions. One of the members takes a more proactive approach to getting feedback and input on issues from other consumers (e.g. through chatting with other parents at the local play centre) but they see themselves more as 'members' than 'representatives' or 'advocates': *'What they get is me, the skills I have and the experience I bring'* [in reference to not actively seeking out views of other consumers].

They have always felt well-supported and respected in their role and feel part of the wider MQSP team. People made a big effort when they took on their roles to welcome them and take them through the unit and meet the staff. They meet with the MQSP coordinator regularly, have recently been allocated a slot on the meeting agenda, and have always felt comfortable raising concerns and commenting on proposals in meetings. The NZCOM role gives them access to a peer network of other consumer reviewers that they can also draw on for support.

They are aware that the maternity service has other ways of getting consumer input and feedback and have offered support to consumer representatives on projects at the service level (e.g. on a normal birth project). They see these other consumer engagement processes as critical, partly in acknowledgement that they are well-educated, Pākehā women that couldn't possibly represent the diversity of maternity consumers.

They feel they've been able to have an influence on MQSP projects, such as on skin to skin contact and a fetal movement project. They have also had an influence on research projects which have come to the governance group as part of the ethics approval process.

The key lessons from the consumer representation at the governance level come down to: defining the role and purpose of consumer representatives; ensuring the right people are appointed to these roles (i.e. a good fit in terms of skills, experience, networks, etc.); and

supporting these people (e.g. understanding what support they need and ensuring they have an opportunity to influence decision making). It is important to note that some maternity facilities, such as primary birthing centres, may have their own consumer representatives in governance roles.

It is apparent that consumers on MQSP governance groups play different roles in terms of who they 'represent'. As discussed in box 7, some consumers see themselves more as 'consumer members' ('...what they get is me...') whose role it is to put a consumer lens over everything, reflecting on what it means for consumers and making sure everyone round the governance table has this lens by asking the right questions (e.g. 'I'm interested to understand how that's going to impact on women; what do you think?'). The NMMG suggested to the evaluation team that having consumer 'members' was more appropriate than 'representatives'. Other consumers on governance groups consider that they have a responsibility to more directly bring to the table the voice of a wider network of consumers by reaching out to and consulting other consumers. They acknowledge that it is unrealistic for them to represent their whole community, but that when they cannot bring a wider community perspective to the table, to recognise this and flag that the programme needs to engage with the perspective that is missing. The evaluation team did not conclude that there is a 'right' or 'wrong' way to look at consumer involvement; however, everyone needs to be clear about the role that the consumers on their governance group do play.

3.8.2. At the service level

Encouragingly, MQSPs are also engaging with consumers in other ways, at service, community and individual levels. At the service level, a number of MQSPs have consumer representatives or members on service change projects, such as new builds, refurbishments and changes to visiting hours; specific projects, such as a normal birthing project and a teenage pregnancy project; and in audits (see box 8).

Box 8: Consumer led BUDSET⁹ audit of birthing suite

In one DHB two consumers audited the facilities in the hospitals' birthing suites using the BUDSET tool which looks at the relationship between birth unit design and safe and satisfying birth. The audit resulted in a number of recommendations, some of which have been actioned (e.g. putting CTG machines into cupboards and purchasing more Swiss balls), and others are apparently in the pipeline (e.g. a new paint job and hanging some art work – which, incidentally, have information on how to massage during labour on the back of the art work). Midwives viewed these changes very positively:

'Nice to see these changes, feel like moving forward. These little things increase morale.'

'Use to be automatically put on CTG; now it is not the first thing you see in the room. It's in the cupboard.'

Other recommendations from the audit have yet to be agreed, including purchasing birthing stools and improving signage to and in the delivery suite.

⁹ Birthing Unit Design Spatial Evaluation Tool.

3.8.3. At the community level

At a community level, one MQSP, which has no consumer members on its governance group, was about to run a series of focus groups with communities through its primary birthing units. The process was being organised by the MQSP coordinator and the plan was to discuss results from a recent consumer survey, ask about how consumers feel about changes the DHB is making as a result of the survey, and ask about their experiences with primary birthing units. Looking further ahead, the DHB was considering establishing a consumer panel or reference group. Another DHB had run consumer forums at its small rural units as part of the MQSP while another had interviewed consumers in the waiting room to find out what was important to them and, as a result, had developed a triage system whereby women are assessed within 15 minutes of arrival and given an estimated waiting time based on this triage. As well as satisfying the consumer's desire to know how long they would need to wait, from a clinical safety point of view, the service has a good understanding of the status of the women in the waiting area. Most DHBs are continuing to use surveys as a way of collecting feedback from maternity consumers.

3.8.4. At the individual level

At the individual level, MQSPs are largely using traditional methods of consumer engagement such as feedback cards and forms and complaints processes, but sometimes with the support of new technology such as tablets and voting buttons. One DHB is trialling the use of feedback cards that are collected daily, collated into themes monthly and discussed at quality meetings. This is providing close to real time feedback (compared with a periodic survey) and is being used as a basis for identifying quality improvement projects. The feedback cards are considered a step before a complaint, and therefore it is also hoped that they will not only help to mitigate formal complaints, but also provide a process where consumers can be heard and the DHB can learn in a less pressurised engagement: *'A complaint is a high bar for many women'*.

Engagement processes at these lower levels (community and individual consumer) did not begin with the MQSP. However, in a number of cases, the MQSP is making a difference:

'What MQSP adds to things like feedback cards is getting follow through. It never feels like it is meaningless data ... [name of MQSP coordinator] is turning information into action'.

3.8.5. Improvements

There are multiple ways that consumers can be engaged in local MQSPs and no 'one size fits all'. However, across all levels of consumer engagement, there is room for improvement in:

- Ensuring that, at a governance level, the right consumers are appointed and supported to fully and effectively participate and be able to influence decision making.
- Finding effective ways to engage with consumers who are less likely to have the skills or drivers to effectively engage yet represent those consumer populations who experience poorer health outcomes. This might include younger solo mothers, those with lower educational achievements and perhaps women living in areas of greater social deprivation. Common comments made to the evaluation team included:

'The people you'd like to talk to are not prepared to talk'.

'We get the usual suspects – but you don't get the consumer representatives that you need to hear from'.

'How should you get feedback [from vulnerable women], buttons and forms? No. Ask them and write it down'.

- Strengthening engagement with specific ethnic groups and consumers from rural/remote areas.
- Ensuring there are opportunities to use information and feedback gained.
- Close the loop by providing feedback to consumers and communities about changes made or not as a result of consumer engagement.

3.9. Local clinical data is being used to identify and understand issues and problems

This section reports on how well local data monitoring supports MQSPs. Issues specific to the national Maternity Clinical Indicators are discussed in section 4.1.4 below.

3.9.1. Use of data

MQSPs are clearly using data to inform quality improvement activities and data is often the starting point to a quality improvement cycle. Not surprisingly, the extent to which individuals engage with data depends on their role and on their background. Most people are aware of relevant clinical and service data, but do not know the details. Others are high-end users, including a number of MQSP coordinators, who are regular users of population health datasets or clinical data on individual cases, such as on the 29 triggers for case review processes (discussed in box 4). Clinical dashboards are being used to make local performance data more visible across a wider group of staff, but there does remain a challenge in raising awareness of data across local maternity networks. For example, while intranet statistics shows people are accessing data dashboards in increasing numbers, awareness of the data among midwives on the ground is low. Furthermore, electronic data remains difficult to access from outside hospital settings.

The quality and depth of analysis applied to local data has increased, in a number of cases, though it cannot all be attributed to the MQSP. For example, business analysts at two DHBs commented that staff are getting better at framing their data related questions and requests, and as a result, extracting data to answer specific questions has improved. The use of data for review processes implemented under the MQSP and for clinical audit processes demanded a greater level of analysis and is changing the way data is used:

'Monitoring the data was the old way of doing things. Now we are looking at data in depth, looking at outcomes, looking at it from a multi-disciplinary perspective, and with a focus on learning'.

3.9.2. Barriers to the effective use of data

There are substantial barriers to the effective use of local data to drive quality improvement activities, including problems with coding, accuracy, completeness, access and incompatible IT systems. The five MQSP case studies identified the following barriers to effective data use:

- **Data systems:** In one DHB the maternity unit is still using a paper-based system which makes it very difficult to share data across the hospital, and very labour intensive to

undertake data audits. In another DHB the databases at two facilities do not talk to each other and a manual process is required to compare data and reporting across sites.

- **Accuracy:** Accuracy of data is considered a huge stumbling block in one DHB, although coding and documentation has recently improved. More generally, DHBs spoke about a greater awareness of the importance of accurate documentation and coding as a result of audit processes having highlighted errors. Interestingly, one DHB reporting improved relationships between clinicians and administrative and management staff as a result of improved data accuracy.
- **Trust and confidence:** Several clinicians reflected on a lack of confidence in data associated with concerns about its accuracy. Mistrust is more commonly associated with how data had been used by the DHB in the past, and the lack of 'safety' around clinical review processes. While some stakeholders reported feeling more confident in the quality of the maternity data, it is taking time to build this confidence in a number of DHBs. In terms of trust, however, this is an area where the MQSP does appear to be making a difference. In several MQSP case studies, data use is now more connected to clinical practice, and the processes for doing this (such as case reviews and clinical audits) are, as mentioned earlier in this report, more transparent, inclusive and 'safe' than previous practices. This is helping to build trust in the use of maternity data.

3.9.3. Annual reporting

Under the New Zealand Maternity Standards (audit criteria 8) DHBs are required to produce an annual maternity report. The MQSP also requires DHBs to produce a report on maternity services and outcomes. Most DHBs have produced two annual reports (for 2012/13 and 2013/14). A small number of DHBs produced annual clinical reports prior to the MQSP.

All case study DHBs have produced two annual reports. In one DHB there was little ownership over its first report which was put together by the MQSP coordinator, circulated for comment but received no responses. One key stakeholder at this DHB claimed not to have had an opportunity to sight it until *'after the fact'*.

Overall the annual reports are highly valued in the case study DHBs. Clearly they take a lot of work (e.g. they can be up to 150 pages) and the evaluation team received positive feedback:

'Really like the annual report. It is publicised, celebrated and also very transparent about the challenge we have. It is one of the most valuable [parts of the MQSP].'

'I would like to see it celebrated; but also critiqued.'

In some DHBs the annual report drives the workstreams for the MQSP, and it provides a reference point for the programme. In one or two of the case studies it is embedded within the maternity service's annual monitoring and reporting cycle. One DHB reported that other hospital services were asking for an annual report *'like the MQSP annual report'* where they could document and publicise their performance against national clinical indicators.

The evaluation team was very impressed with the standard of a number of the annual reports. They provide a very good overview of service delivery, performance and outcomes. In response to the considerable work that goes in to preparing the reports, there may be an opportunity to make some of them more focused and succinct.

The 2014 NMMG Annual Report notes that, while there are several areas of MQSP annual reports that need improving, there has been an overall improvement in the quality of 2013/14 annual reports compared to 2012/13.

3.10. MQSP coordinators are the lynchpin of the programme

All five case study MQSPs have invested funding in staff to lead, manage, coordinate and administer the programme. Most funding for personnel has gone into the establishment of the coordinator position, which are funded between 0.4 and 1.0 FTE across the five case studies. Some DHBs have used funding to support other personnel with roles in the programme. For example, one DHB has increased hours and funding to five other roles that support its programme's implementation. One MQSP had not had a coordinator in place for eight months and several stakeholders at this DHB lamented on the lack of progress in the absence of someone to drive the programme.

The critical importance of the coordinator function was universally recognised:

'Critical to have one person, with an overall, helicopter view'.

'[The coordinator] is the driving force ... the link Can bring in ideas to the coordinator and she drives them. Gives it [the programme] impetus and momentum'.

Stakeholders reported on the competencies and attributes required to fulfill the MQSP coordinator function, and which many recognised within their current coordinator.

Box 9: Key competencies and attributes of MQSP coordinators

- Having strong relationships with the maternity unit and visibility on the floor.
- Effective at bringing clinical leaders on board and gaining their respect.
- Being well linked and having strong relationships with management, planning and funding, and public health.
- Being a skilled *'facilitator, negotiator and de-escalator'*.
- Being analytical and visionary.
- Being supportive and encouraging, and able to build a 'safe' environment.

Some stakeholders felt that it is critical that the MQSP coordinator have a midwifery background. Three of the five coordinators engaged in the case studies do have this, and there are some obvious benefits to this, particularly if their experience is at their current DHB and in both community and core roles. The other two coordinators do not have clinical backgrounds; one has a background in public health and one in administration. It is difficult to judge how critical the clinical background is to the coordination function; certainly it is not sufficient alone, and a coordinator with no clinical background but strong clinical support and holding the competencies shown in box 9 could be just as effective in the role. The coordinator role does

require administrative competencies too, and several stakeholders felt that the role might require more administrative/clerical support around it in the future.

Stakeholders in two DHBs commented on the salary for the coordinator function, saying that they did not feel it was commensurate to the job responsibilities. In one case they felt that the coordinator salary was not sufficient for the skills required and that this was why they had only been able to attract someone in a more administrative role. In another case there is dissatisfaction with the salary and there would appear to be a serious risk of losing the coordinator. It was presumably difficult pricing the coordinator job given the role and the programme were new. Now that the role and programme are established, it would seem prudent for DHBs to undertake a job evaluation based on the actual functions and responsibilities being performed or on the expected functions and responsibilities.

Four of five of the case study MQSPs were established within and remain coordinated from the hospital department responsible for maternity care. The remaining programme was established under the Planning and Funding department, but had not gained any momentum and was in the process of moving to the provider arm of the DHB at the time of this evaluation. Stakeholders at this DHB reported that the funding got '*stuck*' in Planning and Funding, funds were not utilised and that there is a need to ring-fence the MQSP funding.

Three case study programmes have reasonably strong, sometimes recent, links with the wider DHB quality programme and team, and particularly with other quality roles embedded within the service arm responsible for maternal health (e.g. Women and Child Health). In one DHB the coordinator role is likely to move and report into the DHB quality team in the future.

4. TO WHAT EXTENT ARE NATIONAL SERVICE IMPROVEMENT TOOLS, STRUCTURES AND SUPPORT CONTRIBUTING TO CHANGES IN LOCAL MATERNITY QUALITY AND SAFETY?

As part of the MQSP, the Ministry, in collaboration with relevant professional organisations and working groups, developed a range of national tools and structures to support the effective and consistent implementation of local MQSPs. Some national tools and structures were established when the MQSP was first rolled out nationally, such as the NMMG. Others involved revisions to existing tools and structures. A description of the national tools and support structures is included in Annex B. The roles of the national tools and structures overlap, complement, and often refer to one another.

4.1. National tools and guidelines are well-aligned with local MQSPs but are used and valued differently

National tools and guidelines appear to be providing a strong framework and reference point for local MQSPs, and have helped to raise the status of local programmes. Overall there is reasonable awareness of the various tools and guidelines, but most stakeholders engaged in the case studies do not have a detailed understanding of them. As with the MQSP, numerous stakeholders felt that national tools and structures are just beginning to have traction now:

'I think that it is still sort of early days for them to be of use in some respects like the Referral Guidelines have always been there and are very much accepted and well-utilised But I think things like the Standards and Clinical Indicators are gaining traction but still not clearly understood and discussed ... and I think that's purely a time thing as people get them, get familiar, interested and rolling off their tongue easily So in essence a very good framework, but in terms of widespread understanding, acceptance and how you can actually relate the programme to the tool ... there's just a little bit of a gap ... I think it is still a rolling process.'

4.1.1. National guidance, tools, structures and support are largely beneficial

As part of its guidance and support on the MQSP, the Ministry of Health:

- Ran a national conference and local roadshows for DHBs prior to rolling out the MQSP.
- Provided guidance on implementing the MQSP and on strategic plans and annual reports.
- Coordinates monthly teleconference meetings and annual face-to-face for all MQSP coordinators.
- Have run two national MQSP consumer forums.

The level of guidance and support provided by the Ministry has, largely, been welcomed and considered beneficial. Most participants in the evaluation felt that the level of local flexibility versus national prescription is *'about right'*, and reported positively on the tools, monthly teleconferences, information sharing and insights into what other DHBs are doing gained through these processes.

The one potential gap, or area for improvement, identified by a number of stakeholders is support for MQSP coordinators. Clinical directors reported having a chance to share experiences with their MQSPs through their quarterly national meetings. Consumer representatives, similarly, valued the opportunity to share their experiences and ideas at the two national forums. MQSP coordinators valued their monthly teleconferences and a number have established regional networks with neighbouring DHB MQSP coordinators. However, it is also apparent that they have lacked the opportunity to share experiences and ideas in-depth that could be provided by regular face-to-face opportunities.

4.1.2. The NMMG provides critical guidance and drive for quality improvement, but sometimes this is seen as ‘too much’

The role of the NMMG, as an advisor to the Ministry of Health, is to oversee the maternity system and to ensure that the New Zealand Maternity Standards (see 4.1.3) are being implemented. As part of this role, the NMMG provides support to local MQSPs through review of their strategic plans and annual reports, and providing written feedback on what is going well, and opportunities for local improvement. In order to advise the Ministry, the NMMG relies on information provided by DHBs and one of its main activities in connection to the MQSP is requesting information on how DHBs are responding to nationally identified priorities.

Findings from the MQSP case studies show that the NMMG is largely perceived as a positive and important component of the MQSP, focussed on driving changes and achieving outcomes:

‘Need someone there asking the hard questions’.

‘The NMMG focuses the mind. It gives me a lever to get others on side’.

‘It [the NMMG] creates work; but I like it’.

Many of the quality improvement activities discussed in section 3.4 were initially identified through the NMMG’s oversight.

Some DHBs have experienced challenges responding to the correspondence from the NMMG. This appears to be an issue of workload and competing priorities; rather than an issue with the content of the requests. The main findings include:

- A perception that responding to national priorities does not leave sufficient time for local initiatives, and that it *‘sometimes dilutes your efforts from having to continually re-focus’*.
- Concern that the timeframe expectations in terms of (a) responding to NMMG requests, and (b) changing practice, are too quick, especially for large, bureaucratic DHBs. One example is from a DHB that felt it was putting a huge effort into establishing effective maternal mental health pathways, while at the same time having to respond to a series of requests from the NMMG as to what progress was being made.
- Not being sure or having sufficient warning about what might come next from the NMMG. It was suggested that the NMMG’s processes could be *‘refreshed’* and made more transparent, for example, DHBs be provided with meeting minutes and receive advanced warning of priority areas and justification for these areas.
- A desire for more balanced feedback from the NMMG, with a greater focus on what is going well in addition to areas for improvement.

4.1.3. The New Zealand Maternity Standards are part of the quality improvement 'toolkit' but are not explicitly used in MQSP activities

Local MQSPs have considered how they align to the New Zealand Maternity Standards and most DHBs report on how they are meeting the Standards in their MQSP annual report, with some referring more explicitly to the audit criteria in the Standards than others (i.e. provide more detail on their performance against the Standards). However, the Standards are rarely used, explicitly, to drive or inform quality improvement activities. For example, local audit and case review processes are driven by clinical indicators and guidelines, and stakeholders did not discuss the relevance of the New Zealand Maternity Standards to these processes. That said, the Standards are clearly part of the 'toolkit' for maternity quality improvement and have provided a consistent framework for reporting and establishing priorities.

4.1.4. The Maternity Clinical Indicators are a starting point for many quality improvement activities

The Ministry supports local MQSPs by producing benchmarked data for DHBs, showing their performance against the Maternity Clinical Indicators. DHBs are expected to comment on the Clinical Indicators data and reasons for any variability in their MQSP annual reports. All DHBs mentioned the Indicators in their 2012/13 reports, but only some identified areas for quality improvement action or further investigation based on their performance against the indicators. In 2014, the NMMG reported that maternity coders are under-supported which is impeding national data consistency, and that the Ministry and DHBs must address this through, for example, providing more education.

Across the five MQSP case studies, there are numerous examples of where a DHB has identified an outlier in their Maternity Clinical Indicator data that has been the starting point for a quality improvement activity, such as a clinical audit. Some of these processes have led to changes in practice, as previously discussed, while others:

- have led to the identification of documentation and coding errors (which have led to education initiatives)
- have been linked to the practice of specific clinicians (who may no longer be with a service)
- have not resulted in changes because the findings have been considered within the margin of error for what is often a small population.

Evaluation participants reported that there is some awareness of Maternity Clinical Indicators among midwives: *'People know of them; they don't know the ins and outs'*. The value of having a consistent set of national indicators that enables benchmarking with other DHBs is widely acknowledged. Some stakeholders questioned the relevance of all the indicators (e.g. *'an episiotomy isn't necessarily a bad thing'*) and want to see more indicators focused on measuring things that make a difference to the health outcomes, including for the baby. Others noted disagreements around the definitions within the indicators (e.g. *'standard primiparae'*), while it is not uncommon for clinical staff to remain unconvinced about the accuracy of the indicator data. The timeliness of the national data (2012 data was reported in 2014) is another issue affecting its utility: *'It's too old by the time we see it ... we would have already identified and addressed any issues'*.

4.1.5. The development of local guidelines and protocols is informed by National Clinical Guidelines

As discussed in section 3.4, a number of MQSPs have focused on updating local guidelines and protocols. Where national guidelines are available (e.g. for treatment of PPH, management of gestational diabetes and for referral), these are being used as a basis for establishing or updating local guidelines. Participants in the evaluation valued the principle of consistency promoted by national guidelines but also the opportunity to 'regionalise' them by making them more relevant to local contexts.

There appears to be some inconsistency in the application of the Referral Guidelines. The national Referral Guidelines do permit a degree of flexibility but stakeholders at two DHBs reported that local guidelines are being used differently, and sometimes do not appear to be used at all. One DHB has established 'transfer of care' stickers to support the implementation of Referral Guidelines by marking clear boundaries around who is responsible for decisions about maternity care. Others reported improved practices as a result of the Referral Guidelines:

'Seen improvements in transfer of care processes. Know each other's expectations/backstories. Now feel more confident.'

As part of their 2014/15 workplan, the NMMG aims to recommend a framework for use by the Ministry for the endorsement of new national guidelines, and to review maternity guidelines prepared by professional colleges and groups, that are submitted to the Ministry. Some DHBs ensure that clinical guidelines are made available to all staff via Intranet sites and other communication channels. However, some stakeholders reported that accessing guidelines is made difficult by '*impenetrable IT systems*'.

4.1.6. Results from the latest National Maternity Consumer Survey may show how the national MQSP has impacted on consumer experiences of maternity services

The last national consumer survey took place in 2011, and provided information to support the setup of local MQSPs. The results from the next consumer survey, due out in August 2015, should provide valuable information about how maternity services have supported consumers—and how satisfied they are with maternity services—since the roll-out of MQSPs. However, we found that the results of the last national survey were not widely read and, as noted earlier in this report, DHBs are placing considerable emphasis on getting feedback on consumer experiences through their own mechanisms, which have been well-augmented by the MQSP.

4.1.7. New information and data management systems have the potential to support MQSPs

The new Maternity Clinical Information System (MCIS) project is still being rolled out across DHBs so it is too early to tell how well it is supporting the MQSP. As one of the main intentions of the project is to improve information sharing between community and hospital-based clinicians, and eventually to women and their families/whānau, the MCIS has considerable potential to support MQSPs.

5. HOW SUSTAINABLE ARE LOCAL MQSP PROGRAMMES AND ACTIVITIES?

At the time this evaluation was designed, funding for the MQSP had been confirmed through to 30 June 2015, at which time DHBs were expected to continue to operate MQSPs as business as usual. Ongoing funding for MQSPs has since been approved. This section considers the extent to which MQSPs have become embedded within the health system, and what needs to happen in order to continue and improve on the positive changes achieved to date.

5.1. The MQSP is not yet embedded as core business within DHBs

The findings from the five MQSP case studies support the finding in the interim evaluation report that:

'Some DHBs have embedded the programme to the extent that they would probably continue it with no further support. Other DHBs are taking their first steps with the programme Without further support, it is likely that the majority of local MQSPs would fall over or limp along.'

As noted earlier in this report, one case study's MQSP never really got started while another's is reasonably well embedded and would probably continue regardless of external support. The majority of MQSPs are not yet embedded as core business and, as a result, the evaluation evidence suggests that if ongoing support were not provided:

- MQSP coordinator positions, which provide people with *'a one-stop-shop for maternity quality'*, would be disestablished and responsibilities be dropped or tacked on to someone else's job.
- Many projects and initiatives would continue, but no new projects would be developed and the momentum and scope of projects would be reduced. For example, projects would be more likely to continue in the hospital, but not across the sector: *'Likely lose the periphery and just focus on the hospital [it would be] a slow death'*. People in regions who have been engaged through MQSP networks (e.g. in governance roles and quality improvement activities) would return to feelings of *'isolation'*. The number of quality improvement activities would be reduced which might involve, for example, randomly selecting clinical cases to review rather than reviewing all *'triggered'* cases, or doing as many reviews but cutting down on the dissemination of learning from the reviews.
- Some projects would be dropped: *'Would recede to where it was: quality in the service spec. but nobody doing it.'*
- There would be a reduction in inter-sectoral work and *'a return to working in silos'*, although initiatives that pre-date the MQSP, such as community midwife interface meetings, would continue.
- Improvements and gains achieved in areas like data quality would *'flatten out'*.
- A lot of trust that has been built up across the sector would be lost: *'gone so far; can't just let it go'*.
- Quality initiatives would become *'opportunistic, rather than planned and resourced.'*
- Some quality improvement activities and responsibilities would get picked up by, and subsumed within, wider DHB quality programmes.

Some stakeholders related the extent to which the programme has become embedded to the broader context for their DHB, such as the MQSP coming at a time when there was a lot of other change going on in the sector or for their DHB, or it just taking a long time to implement change processes: *'DHBs are big beasts; change takes time'*. Others commented on the type of change they were trying to achieve, which required complex and broad cultural change such as *'teaching people that the abnormal is not normal'*. This was contrasted with HQSC quality and safety initiatives such as hand hygiene in care workers which have clear aims, measures, and a clear pathway, and are considered easier to embed.

The need for ongoing resourcing is considered paramount by the vast majority of stakeholders. Many participants spoke of the lean resourcing environment that DHBs operate in, and within this context the difficulty that they would have in getting approval to continue the MQSP coordinator position. Others commented on the need for ring-fenced resourcing: *'When the money goes to the [DHB's] bottom-line, historically we don't see it'*.

The following quote sums up the situation for many MQSPs:

'Taking funding away would be like a handbrake. [We have] momentum going now ... things are changing in last 18 months ... but it is not yet a habit We're seeing benefits for mum and baby It would filter back It is not yet the norm We're still getting there'.

Stakeholders generally considered the programme needs two to three more years of support to become embedded as core business. Once it had become steady state there would likely be a slight reduction in the resources required to sustain it; for example, systems and processes set up for reviewing and updating guidelines would be well-established and processes for putting together the annual report would become more streamlined with experience. However, ultimately, for a DHB to commit ongoing funding (e.g. for the coordinator position), a number of stakeholders felt it came down to the programme being able to demonstrate that a greater focus on quality saves money (e.g. through reduced complaints and incidents) and improves health outcomes. These may only be evident over the medium-long term.

5.2. Sustainability would be enhanced by strong leadership, inter-sectoral collaboration and sharing of good practice

Overall, the MQSP has made a positive start but there is widespread acknowledgement that *'we're not quite there yet'*. Strengthening a number of elements of the programme would increase the likelihood of continued benefits over the long-term, and would help to embed the MQSP as business as usual. These elements—leadership, inter-sectoral collaboration and sharing of good practice—need to be strengthened at both the local and national levels.

5.2.1. Leadership

Leadership for maternity quality and safety at a national level appears critical to the future of the MQSP. The Ministry, NMMG, HQSC and PMMRC need to continue to ask things of DHB chief executives *'otherwise maternity quality and safety will get lost When you have to report, with strict guidelines, things get done'*. At the chief executive (CE) level there may be value in appointing a CE to champion maternity quality at a national level, to raise its visibility by, for example, getting it on the agenda at national CE forums.

At the local level, the evaluation found different levels of management oversight and ownership of the MQSP. There is still a strong feeling by many evaluation participants that maternity comes at the bottom of DHBs priorities. One stakeholder commented that *'they only become interested if they get a letter from HDC [the Health and Disability Commission] or PMMRC'* or when *'it [a quality issue] smacks them in the eyes'*. Ideally, strong local leadership includes both midwifery and obstetrics leaders who can engage the wider service in the programme both up the line to management and planning and funding, and at the shop floor.

In addition to leadership, it is clear that the dedicated coordination function remains critical to the continued implementation of the MQSP. Section 3.10 outlined the key competencies required of MQSP coordinators. As well as strong clinical support, the MQSP coordinator role could be enhanced by adding some administrative support around quality improvement processes.

5.2.2. Inter-sectoral collaboration

'We can be doing all of this internally ... but it [maternity quality] is a much deep-seated problem. It is women's health; it is family health; that is what it is. It goes all the way back into the homes.'

The MQSP has an interdisciplinary focus and has reached outside of the hospital sector. This is a real strength. However, the MQSP's focus has largely been on maternity practitioners and on DHBs as institutions. In order to ensure its benefits continue and grow, the time is right for the MQSP to give greater focus to extending out into other sectors.

At a national level, the MQSP should build stronger relationships with primary health care. This might involve, for example, strengthening GP representation on the NMMG and bringing RNZCGP into the programme in order to promote greater engagement by general practice in programmes at a local level.

At a local level, MQSPs have engaged well with community midwives and consumers, but there is a need to strengthen this engagement by ensuring two-way engagement that filters useful information and issues up, as well as down. There is also a need to strengthen processes that engage with vulnerable women and their whānau, which might involve extending networks to Māori health providers, Whānau Ora providers and Well Child /Tamariki Ora providers.

Perhaps the biggest gap in collaboration at a local level is between secondary and primary care. MQSPs need to extend their reach into primary care, including primary birthing units, regional hospitals providing primary care and general practice. Much more progress has been made with DHB facilities and primary birthing units and there is good practice to build on. However, engagement of GPs in the MQSP needs more work. The current separation at the community midwife-GP interface needs to be worked through in acknowledgement that maternity quality and safety is about a woman's journey and cannot be addressed through maternity services alone. Engagement should be addressed at multiple levels (e.g. DHB-PHO through to GP-community midwife), and through multiple methods (e.g. involvement in relevant quality improvement activities and, potentially, in programme governance).

5.2.3. Sharing good practice

The variation in local MQSP implementation progress and effectiveness suggests the potential for some programmes to benefit from the practices or approaches adopted by others. There is some sharing happening, through monthly MQSP coordinator teleconferences, annual consumer

member workshops, informal collaborations between individuals across DHBs and formal collaborations between multiple DHBs across a region. But several evaluation participants feel that they are left to do their own thing, while knowing everyone else is in the same situation. Further opportunities for sharing good practice that were suggested by participants in the evaluation include:

- Exploring opportunities to buddy MQSPs so one that has made good progress would provide peer-support to another.
- Extending the role of MQSP coordinators or appointing champions who would have a role of visiting local MQSPs and providing direct support.
- An annual MQSP forum where representatives from local MQSPs and from the NMMG come and share good practice and learn from others (similar to the PMMRC's annual workshops and the annual MQSP consumer workshop).
- Establishing an online site for sharing resources across MQSPs, such as annual reports, local protocols and guidelines, and health promotion materials. Enabling coordinators to refer to similar resources could save significant time.

Within a DHB there would appear to be opportunities to promote more sharing of quality improvement practices and methods through greater alignment between the MQSP and wider quality initiatives. While most evaluation participants considered much would be lost by fully integrating the MQSP into the DHB's quality department (e.g. *'Would risk losing focus if it sat with corporate quality. Would be a disaster as would get swamped with their issues/priorities'*), it was acknowledged that there are benefits to be gained from working together more closely. For example, it would give MQSPs more exposure to a wider range of quality improvement methods, greater visibility in the DHB, and more exposure to the ideas of a wider team of quality specialists.

6. CONCLUSIONS AND RECOMMENDATIONS

This evaluation demonstrates that there has been considerable progress and success in the implementation of the MQSP. As a maternity quality and safety initiative, the programme has significant merit; within the right set of circumstances it is beginning to gain real traction and to make a difference. Within other contexts, such as where there has been a lack of programme ownership or the existence of wider confounding factors beyond the programme's direct influence, the value added by the MQSP has been less apparent.

The changes the MQSP is seeking to make take time. The visibility and intensity of the various quality improvement processes and activities being delivered under the MQSP is helping to drive a cultural change that is both very reflective of practice and also inclusive. The evaluation team strongly believe that it is a journey worth pursuing and that the time is right to make some adjustments to the pathway to maximise benefits for women, babies and their whānau.

The recommendations in the interim evaluation report included that *'the Ministry of Health continue to provide funding support to implement local MQSPs in all DHBs'*. This recommendation has been actioned. The final set of evaluation recommendations, below, are designed to further improve the implementation of the MQSP within the context of the Ministry having agreed further funding.

6.1. Strengthen leadership

The evaluation findings highlighted the importance of multi-disciplinary leadership to building ownership of the MQSP, and the evaluation found gaps in leadership at various levels. Stronger leadership of the MQSP at the national level and the health service level, in addition to the local MQSP level, will strengthen the visibility and influence of the programme.

Recommendation 1

1. Strengthening multi-disciplinary leadership of the MQSP at all levels of the health system.

- 1.1. The Ministry of Health and the NMMG continue to provide national leadership for the programme with a focus on ensuring coherence across respective MQSP-related functions and clear linkages with health quality and safety functions of other national bodies including the HQSC and the PMMRC.
- 1.2. The National DHB CEO Group strengthen health service leadership of maternity quality and safety by the nomination of a DHB chief executive as a 'maternity quality and safety champion'.
- 1.3. DHBs be required to have joint midwifery and obstetric MQSP leadership positions.

6.2. Extend scope and sector engagement

The evaluation found that, while the MQSP has helped to extend the scope of maternity quality and safety into the community, it has been most effective at engaging practitioners within the confines of the hospital, and to a degree with community midwives. It has been less effective in engaging with practitioners in primary care and other community settings. Stronger engagement from practitioners within these settings would help to extend the scope of the

programme across a woman's journey through health services and extend local maternity networks to include services targeting vulnerable women and their whānau.

Recommendation 2

2. Extend the scope and value of sector engagement in the MQSP and in local maternity networks.

- 2.1. DHBs enable community midwives to engage in MQSP governance and quality improvement activities in meaningful ways that respect and value their experiences and contributions. This includes addressing any barriers, including time and cost, to their involvement in MQSP governance roles.
- 2.2. Strengthen the engagement of GPs and PHOs in the MQSP, including by:
 - The Ministry of Health consider appointing a practising GP to the NMMG, potentially nominated by the RNZCGP.
 - The Ministry of Health review Service Specifications around confirmation of pregnancy and LMC booking to ensure better two-way communication between GPs and community midwives when a woman first makes contact about pregnancy.
 - DHBs proactively target GP involvement in quality improvement activities and projects, preferably alongside community midwives.
 - DHBs target engagement from the small number of GPs who are practising LMCs.
 - DHBs address any barriers, including time and cost, to GP involvement in MQSP governance roles.
- 2.3. DHBs build understanding of the context within vulnerable communities and how this impacts on maternity experiences and outcomes by strengthening engagement with primary, community and social sector providers and initiatives that work with vulnerable pregnant women and their whānau.

6.3. Make more effective use of consumer engagement

In the interim evaluation report we recommended that ongoing funding cover the costs associated with having at least two consumer members on MQSP governance groups. Within the case studies, the evaluation found a far wider spectrum of consumer engagement practice, with examples of both very effective and very poor engagement. No one mechanism for consumer engagement meets all needs, and, in particular, a focus on governance alone is too narrow. The MQSP would benefit from effective consumer engagement processes at all levels, including from individuals and communities, and in service improvement projects as well as in governance roles.

Recommendation 3

3. DHBs be required to show how they effectively engage with consumers and use information and expertise gained through this engagement.

- 3.1. DHBs address the support consumers need to engage meaningfully.
- 3.2. DHBs ensure all consumer engagement respects and values consumer experiences and contributions.
- 3.3. DHBs respond to the needs of consumers who may experience barriers in engaging effectively.
- 3.4. DHBs strengthen processes for using consumer input to influence decision making and service delivery.

6.4. Continue to invest in dedicated programme coordination

In the interim evaluation report we recommended that ongoing funding cover the costs associated with the coordination of MQSP implementation. The evaluation case studies found that the effectiveness of the implementation of the MQSP has a lot to do with having an active coordinator, who is effective at bringing clinical leaders on board and has strong relationships with the maternity unit, including visibility on the shop floor. Where a dedicated resource or coordinator is not in place, the programme has stalled. The MQSP is not yet embedded within core practice and this dedicated coordination resource remains critical to the continued implementation of the programme.

Recommendation 4

4. Resource the MQSP.

- 4.1. DHBs ring-fence MQSP funding for implementing maternity quality and safety activities until these activities are embedded as core practice and a programme budget is no longer essential to continue the activities.
- 4.2. DHBs dedicate a proportion of the ring-fenced funding to local programme coordination and administration with remuneration reflecting the importance of these roles.

6.5. Share good practice

In the interim evaluation report we recommended that further guidance on the MQSP and peer-to-peer learning events or networks be developed to share lessons and good practice. In the case studies, the evaluation found a lot of good practice being generated, but limited opportunities to share lessons and ideas across local MQSPs about what has worked well and what has not. Opportunities to share good practice would contribute to more effective and more efficient programmes by avoiding having to continually 'reinvent the wheel'.

Recommendation 5

5. Facilitate learning and sharing of practice across DHBs.

- 5.1. The Ministry of Health, in collaboration with DHBs, establish a mechanism for DHBs to provide direct peer-support to other DHBs. This might include appointing MQSP coordinators or other experts as buddies or MQSP champions.

- 5.2. The Ministry of Health run an annual MQSP forum or workshop for representatives from local MQSPs and from the NMMG.
- 5.3. The Ministry of Health establish a 'one-stop-shop' online site for sharing resources across MQSPs, including: NMMG and MQSP annual reports; example guidelines and policies; templates for MQSP annual reports, local guidelines and policies; case studies showcasing good practice; and links to quality and safety resources provided by other organisations such as the HQSC.

ANNEX A. EMBEDDING AND EXPANDING THE MATERNITY QUALITY AND SAFETY PROGRAMME: A CONSULTATION DOCUMENT FOR DISTRICT HEALTH BOARDS

Executive Summary

The MQSP is currently playing an important role in raising the profile of maternity quality and safety. Overall, maternity quality and safety is, as a result of the MQSP, more accepted and embedded at a system level.

The Ministry of Health funded the MQSP for four years to June 2015 on the expectation that the MQSP would operate as business as usual after this time. Overall, progress in implementing the MQSP has been slower than expected and there has been differential progress across DHBs to date. However, change at a whole of service level takes time and initial expectations may have been unrealistic, given other factors at play in some DHBs.

All intelligence gathered to date suggests that without further support, it is likely that the majority of local MQSPs would fall over or 'limp along', and DHBs (and women) would not be able to gain full benefit of the advances made over the last few years.

The Interim MQSP Evaluation undertaken by Allen + Clarke Policy and Regulatory Specialists recommends the Ministry of Health continue to invest in local MQSPs.

The Ministry has had high level agreement from the Minister of Health to continue investment in improving maternity quality and safety. The Ministry is progressing internal approval to confirm our investment in DHB MQSPs. This is an opportunity to learn from our experience and contract more effectively in future to achieve MQSP aims.

This paper sets out a three tier approach to future MQSP funding, where DHBs would self-identify their category based on the maturity of their current MQSP, and take on service specifications and contract terms that reflected this. All tiers would receive the same level of funding.

When a DHB was able to demonstrate they were delivering a woman-centred, integrated maternity service that undertook continuous quality and safety improvement without oversight and direction from the Ministry of Health, their share of MQSP funding would be transferred to their DHB's baseline.

The Ministry seeks DHB feedback on the proposed approach, which (if funding is secured) would take effect from 1 July 2015.

DHB Maternity Quality & Safety Programmes to date

DHBs began local Maternity Quality and Safety Programmes (MQSPs) in 2012. By 30 June 2015, DHBs will have received funding to a total of \$10,682,323 via Crown Funding Agreement (CFA) Variation.

To implement the MQSP, DHBs were directed by the Ministry to establish the following:

- Effective **governance structures** with consumer and community practitioner representation and line of sight from MQSP operations to DHB management.

- Strengthening **clinical leadership**, so that improvement projects reflect clinical priorities, and there is effective representation and effective teamwork across all the types of clinicians involved in the delivery of maternity services.
- Programme **administration and co-ordination**, with most DHBs choosing to employ a MQSP Coordinator to drive activity locally, and collaborate with other DHBs and the Ministry.
- Dedicated **data analysis and reporting**, including regular review of birthing population demographics and outcomes, performance against national clinical indicators and local performance measures and an annual publicly available maternity report.
- Increased **sector engagement** in DHB-led quality and safety activity including better information sharing and working more closely with community LMCs, GPs and WCTO providers to identify and address quality and safety issues at the system not hospital level.
- Better **consumer engagement** in maternity quality and safety review and improvement; ensuring there is consumer input at all levels of the programme, and that a range of methods are used to seek feedback and engagement from women and their families, including Maori, Pacific, young mothers and other relevant populations.

The expectation was that the above structures, systems and relationships, once in place, would support identification and implementation of a range of projects to address national and local maternity quality and safety priorities, addressing which, would improve outcomes for women and their families, and the value for money of the maternity system.

It was expected that these structures et al. would take 1-2 years of intensive work to be established, then would become embedded as business as usual and resource could be refocused to local quality and safety projects.

DHBs were informed via the CFA Variation and via communications with the Ministry of Health that there was no guarantee of ongoing funding, and that the core MQSP functions should be able to operate as business as usual (without Ministry funding) from 1 July 2015.

While a few DHBs have fully shifted focus from establishment to quality improvement, most have not, and many still continue to work towards establishing the structures and relationships described above.

This reflects that creating significant and sustainable culture change is complex and time consuming. However, all DHBs have invested heavily in this programme and many are seeing the positive benefit, with greater benefits to be realised with time.

Findings of the MQSP Evaluation

A national evaluation of the MQSP (currently underway), delivered preliminary findings in early March 2015 to inform national and local decision making regarding the transition of this programme to business as usual.

The key findings were:

- The quality and safety of maternity services is, increasingly, at the forefront of DHBs' conversations and activities. This is significant. The MQSP is playing an important role in raising the profile of maternity quality and safety.

- Overall, maternity quality and safety is, as a result of the MQSP, more accepted and embedded at a system level. It is no longer seen as just something that happens inside the hospital setting, but is beginning to acknowledge the importance of community-based practitioners and recognising the needs of specific populations.
- Most DHBs are looking at maternity quality and safety, looking at how they are performing, and are beginning to investigate activities that can make a difference. Some specific local initiatives developed as a result of the MQSP, for example the Top 5 in 10 timely registration initiative, are thought to have made a difference already.
- A programme coordination function, often carried out by a dedicated MQSP Coordinator, has been critical to the success of local MQSPs to date.
- The MQSP involves consumers which is a very new addition to accountability within the DHBs maternity management structures. It is giving consumer representatives a 'place at the table'.
- There has been differential progress across DHBs. Some DHBs have embedded the programme to the extent that they would probably continue it with no further support. Other DHBs are taking their first steps with the programme. Overall, progress in implementing the MQSP has been slower than expected. However, change at a whole of service level takes time and initial expectations may have been unrealistic. Without further support, it is likely that the majority of local MQSPs would fall over or 'limp along'. The Ministry of Health should continue to invest in local MQSPs.
- Maternity quality and safety should be part of a DHB's core business. The MQSP needs to transition to business as usual for DHBs. Future Ministry of Health support should be on the basis of local programmes planning towards operating on a business as usual basis at the conclusion of a new period of support and the development of a clear exit strategy for the Ministry's support.
- Decisions about any future support for local MQSPs need to be communicated as a matter of urgency as the risk of key local MQSP personnel and gains being lost, increases daily.

The evaluation recommends:

1. The Ministry of Health continue to provide funding support to implement local MQSPs in all DHBs
2. The funding period for local MQSPs should be set at three years, should have a clear timetable for a funding end-date and should have annual funding reductions up to this end-date.
3. Funding for local MQSPs should be on the basis of approved DHB strategic plans for the new funding period.
4. The Ministry of Health, with advice from the NMMG, should set out the content requirements for the DHB strategic plans, which will be inclusive of:
 - 4.1 Proposed mechanisms for MQSP coordination and consumer representation functions.
 - 4.2 The roles and responsibilities of staff, community-based LMCs and consumers involved in the programme and how these responsibilities will transition over and beyond the funding period.

- 4.3 How local programmes will increasingly be embedded in business as usual over the funding period, including how they will be integrated with other quality and safety initiatives.
 - 4.4 How quality and safety initiatives will be embedded into clinical practice, including what methods and tools will be used, and how initiatives will achieve staff buy-in.
 - 4.5 How local programmes will engage with experts in quality and safety processes to implement effective change for improved outcomes.
5. The MQSP should be evaluated towards the end of the new funding period to assess both implementation and outcomes.
 6. The Ministry of Health consider the development of further guidance on the MQSP and peer-to-peer learning events or networks that share lessons from good practice and avoid DHBs having to 'continually reinvent the wheel'.

Where to from here?

Given that DHBs are all at different stages of maturity with MQSPs, the best use of Ministry resource (support and funding) differs for different DHBs.

DHBs who are still working to establish a programme need intensive support and monitoring to ensure they put the building blocks in place, and need funding to ensure establishment continues. These are the **Emerging** DHBs.

DHBs who have established programmes need continued support and funding to refocus establishment activity to quality improvement activity. These are the **Established** DHBs.

DHBs who are already delivering quality improvements need freedom to utilise funding in new ways, for example alliancing, to improve outcomes and need Ministry support to remove barriers. These are the **Excelling** DHBs.

The Ministry proposes three contract types. DHBs would agree with the Ministry the contract type that best describes their programme.

Based on the category chosen, contract expectations, term and reporting requirements would differ, as would the engagement of the Ministry. The total value of contract should remain the same over each category, to avoid a perverse financial incentive for DHBs to select one category over another.

Below are a range of criteria that would enable a DHB to self-identify which category they belong in.

Characteristics of the three categories of maturity of MQSP

Emerging

- Programme budget predominantly utilised for programme operations such as administration and coordination, project management
- Programme uses a selection of data and statistics to identify quality and safety priorities including the New Zealand Maternity Clinical Indicators
- All DHB maternity stakeholders can identify the MQSP's vision, objectives and improvement priorities

- Consumers, wider maternity sector and DHB executive are aware of programme and some may be involved
- There is some consumer participation in programme but there may have been high turnover or challenges recruiting, DHB does not have established processes to meet consumer support and training needs
- MQSP is planning projects that will lead to meaningful improvements for women and families but has not fully implemented these yet
- DHB does not yet collaborate regionally or sub-regionally
- DHB has been encouraged to do more by the NMMG and Ministry
- DHB meets some of the New Zealand Maternity Standards Audit Criteria

Established

- Programme budget predominantly utilised for quality improvement projects such as resource development
- All governance structures in place and working effectively, terms of reference are publicly available, group structure and function is fit for purpose
- There is line of sight from activity level to DHB executive
- Consumers are involved at all levels of the programme and multiple methods are used to gather consumer feedback
- Consumer participation in programme is working towards sustainability and DHB is working with consumer members to identify and meet support and training needs
- There is regular review of data and statistics beyond the New Zealand Maternity Clinical Indicators, including dissemination to wider sector and consumers
- Maternity annual report publicly available and well utilised by sector
- Wider maternity sector including consumers can identify the MQSP's vision, objectives and improvement priorities
- Regular involvement of DHB Quality teams in MQSP governance and operation
- Consumers, wider maternity sector and DHB executive support programme
- MQSP is implementing projects that will lead to meaningful improvements for women and families
- DHB participates in regional quality improvement collaboration
- DHB receives mostly positive feedback from the NMMG and Ministry
- DHB meets all or can demonstrate it is working towards meeting all of the New Zealand Maternity Standards Audit Criteria
- DHB has an alliance relationship with local primary care providers that is suitable for the primary maternity sector to join.

Excelling

- Programme budget no longer essential; programme and quality improvement activities are sustainable and met within DHB baselines
- A broad range of consumer perspectives are captured at all levels of the programme and consumer input has led to demonstrable change
- Consumer participation in programme is sustainable and consumer members report good support, training and engagement
- Programme uses national and local statistics and data to inform priority setting, utilises public reporting such as weekly/monthly dashboards or KPIs to monitor progress and drive improvement
- Wider maternity sector including consumers contribute to the development and implementation of MQSP's vision, objectives, improvement priorities and projects
- Co-design and delivery of quality improvement activity with DHB Quality teams
- Consumers, wider maternity sector and DHB executive are actively engaged in programme and this can be demonstrated
- MQSP has delivered meaningful improvements for women and families
- DHB leads regional quality improvement collaboration and provides support and guidance to other DHBs
- DHB receives continuously excellent feedback from the NMMG and Ministry
- DHB meets all of the New Zealand Maternity Standards Audit Criteria, undertakes regular self-assessment and reviews this at governance level at least annually.
- MQSP Annual Reports are publicly available, are endorsed by clinical leaders and consumers and are a well utilised resource.
- DHB has a strong alliance relationship with local primary care providers that may already include the primary maternity sector.

Proposed contract terms for each category

	Term	Service expectations	Budget	Reporting requirements
Excelling	3yrs	DHB identifies 3-5 maternity outcomes that will be improved over the term of the contract and agrees targets with Ministry and NMMG.	Budget may be allocated as DHB sees fit to achieve maternity outcomes, including alliancing, no financial reporting required.	No reporting requirements over and above those set out in the New Zealand Maternity Standards.
Established	2yrs	DHB identifies 3-5 maternity quality and safety improvement projects that will be delivered over the term of the contract and agrees the outputs with the Ministry and NMMG. DHB works towards meeting the expectations of an 'Excelling' DHB.	Budget must be allocated to MQSP operations, financial breakdown to be provided in programme plan.	Two year MQSP programme plan to be submitted in first quarter of contract, including breakdown of how funding will be allocated. Annual Report to be submitted to Ministry of Health by 30 June of each year of contract.
Emerging	1yr	DHB develops project plan that outlines the activities the DHB will do to achieve the expectations of an 'Established' DHB. DHB reports quarterly on activity under the following headings: <ul style="list-style-type: none"> - Governance - Clinical leadership - Coordination & administration - Data monitoring - Sector engagement - Consumer engagement 	Budget must be demonstrably allocated to MQSP establishment, detailed financial breakdown to be provided in project plan and quarterly financial updates required.	MQSP establishment project plan draft to be submitted at end of first month of contract including detailed breakdown of how funding will be allocated. MQSP establishment project plan to be agreed with Ministry by end of second month of contract. Quarterly progress reporting against project plan and financials. Draft Annual Report to be submitted to Ministry of Health by 30 April. Final Annual Report to be submitted to Ministry of Health by 30 June.

Budget

The total funding allocated to DHBs by the current MQSP CFA Variation is \$2.8m per annum (excl. GST). The total funding for the Maternity Quality Initiative including the Maternity Quality and Safety Programme is not yet known. This will be confirmed by the Ministry of Health by the end of April.

For this paper, the future budget has been assumed to be the same as the current budget. This is an assumption for analysis purposes and should not be taken as confirmation of ongoing funding for this initiative.

It is not recommended that the Population Based Funding (PBF) formula be used to allocate budget across DHBs as this does not reflect the distribution of the birthing population in New Zealand and therefore the scale of each DHB's maternity sector.

If the total current MQSP budget was reallocated (\$2.8m) and was distributed based on the DHB's 2013 birthing population, the funding would be distributed as per column A. If the total current MQSP budget was reallocated (\$2.8m) and was distributed based on each DHB receiving a minimum programme budget (\$50k p/a), with the remainder distributed according to the DHB's 2013 birthing population, the funding would be distributed as per column B. The current distribution (fixed sum of \$50k, remainder distributed by the 2008 birth share) is as per column C.

DHB	Births 2013	A) \$2.8m p/a distributed by 2013 birth share	B) \$50k for all DHBs, remainder distributed by 2013 birth share	C) Current MQSP funding
Auckland	6244	\$297,515	\$241,260	\$237,579
Bay of Plenty	2760	\$131,509	\$134,542	\$134,068
Canterbury	5824	\$277,503	\$228,395	\$237,080
Capital and Coast	3638	\$173,344	\$161,436	\$163,900
Counties Manukau	8153	\$388,476	\$299,735	\$298,463
Hawkes Bay	2162	\$103,015	\$116,224	\$116,782
Hutt Valley	1920	\$91,485	\$108,812	\$111,673
Lakes	1422	\$67,756	\$93,557	\$97,453
MidCentral	2122	\$101,110	\$114,999	\$116,163
Nelson Marlborough	1550	\$73,855	\$97,478	\$97,844
Northland	2124	\$101,205	\$115,060	\$116,578
South Canterbury	641	\$30,543	\$69,634	\$68,194
Southern	3451	\$164,434	\$155,708	\$154,646
Tairāwhiti	713	\$33,973	\$71,840	\$72,685

DHB	Births 2013	A) \$2.8m p/a distributed by 2013 birth share	B) \$50k for all DHBs, remainder distributed by 2013 birth share	C) Current MQSP funding
Taranaki	1522	\$72,521	\$96,620	\$95,051
Waikato	5173	\$246,484	\$208,454	\$207,679
Wairarapa	500	\$23,824	\$65,315	\$65,305
Waitemata	7643	\$364,175	\$284,113	\$270,760
West Coast	375	\$17,868	\$61,487	\$62,046
Whanganui	827	\$39,405	\$75,332	\$76,051
Total	58764*	\$2,800,000	\$2,800,000	\$2,800,000

* excludes Overseas and Unknown DHB

Exit strategy

If a DHB met all requirements of an Emerging contract, they would move to an Establishing contract at the end of the one year term. If they did not meet all requirements, they would move onto a subsequent Emerging contract.

If a DHB met all requirements of an Establishing contract, they would move to an Excelling contract at the end of the two year term. If they did not meet all requirements, they would move onto a subsequent Establishing contract or in extreme cases to an Emerging contract.

If a DHB met all requirements of an Excelling contract, their funding would transition to DHB baselines at the end of the three year term. If they did not meet all requirements, they would move onto a subsequent Excelling contract or in extreme cases to an Establishing or Emerging contract.

Proposed Ministry activities 2015/16

- Enter CFA Variations
- Intensively support Emerging DHBs
- Continue to host teleconferences & national meetings
- Continue to fund and support NMMG
- Review Annual Reports for Emerging and Established DHBs
- Work with Excelling DHBs to set up innovation & improvement hubs to support better information sharing and DHB mentoring
- Support consumer engagement including hosting consumer forum and releasing national consumer survey tool
- Work with HQSC to strengthen links between MQSP and Quality Accounts

Next steps

We would like your feedback on this proposal. Please feel free to email your feedback to Laura Ross (laura_ross@moh.govt.nz) by 30 April 2015. The Ministry will also host a series of teleconferences to discuss this proposal in April and May.

Questions to consider:

- Do you support continuation of the MQSP?
- Do you support the Ministry continuing to fund the MQSP via DHBs?
- Do you support moving to the Emerging/Established/Excelling contract model?
- Do you support the three categories as they are currently described?
- Do you support having differential CFA Variation service specifications?
- Do you support the proposed terms of the three CFA Variations?
- If not, how could maternity safety and quality improvement be done differently?
- Do you think the current funding appropriation is sufficient?
- How should the funding be distributed?
- Do you support the exit strategy?
- Do you support the Ministry-led actions for 2015/16?

Key dates

Late March 2015	Expected date for Government's decision regarding future of Maternity Quality Initiative
Early April 2015	Consultation document released
Mid April 2015	Teleconferences to gather DHB feedback
End April 2015	DHB Feedback due
End April 2015	Expected date for decision regarding MQSP budget for 2015/16 onwards
End May 2015	CFA Variation content finalised
Mid June 2015	Omnibus sent to DHBs
1 July 2015	CFA Variation executed

ANNEX B. REVIEW OF MQSP NATIONAL TOOLS

1. National guidance and support to DHBs

Ministry of Health staff provided (and continue to provide) guidance and support to DHBs to implement and report on their MQSP. The NMMG is a key component of national guidance and support for MQSPs (2). Planning for the MQSPs began in 2010, after the Ministry released a draft Maternity Action Plan for consultation, and submissions received showed consistent support for a quality and safety programme for maternity. Ministry staff coordinated and assisted with the development of other national tools, such as the Maternity Standards (3), Clinical Indicators (4) and Clinical (5) and Referral (6) Guidelines. They also ran a national roadshow for MQSPs – early-mid 2012, prior to rolling out the MQSP across DHBs.

Ministry of Health resources for DHBs include the following documents:

- Implementing the Maternity Quality and Safety Programme in your DHB: A Guide
- Framework for DHB Maternity Quality & Safety Strategic Plan
- MQSP Annual Report 2012/13 Guidance
- MQSP Annual Report 2013/14 Guidance
- MQSP Annual Report 2014/15 Guidance

The MQSP coordinators network includes monthly teleconference meetings facilitated by Ministry staff, where local MQSP coordinators are able to share information about what is working and what's not.

The Ministry has also facilitated two MQSP consumer forums, and consumer representatives have developed their own support networks (e.g. a Facebook page).

Professional organisations that also provide support to DHBs and MQSPs include the New Zealand College of Midwives (NZCOM), Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Paediatric Society of New Zealand, and the Health Quality and Safety Commission (HQSC).

2. National Maternity Monitoring Group (NMMG)

The NMMG was established in 2012 by the Ministry as a component of the Maternity Quality Initiative (MQI), which the national MQSP is part of. The NMMG provides an overview of the quality and safety of maternity services through their review of local MQSP Strategic Plans and Annual Reports.

The purpose of the NMMG is to oversee the maternity system in general, and the implementation of the New Zealand Maternity Standards (see below). NMMG members include: clinical sector experts in midwifery, obstetrics, neonatal paediatrics, primary care, clinical research, and obstetric anaesthesia; and a consumer representative. They meet at least four times per annum.

The NMMG agrees a 12-month work programme with the Ministry at the beginning of each year of operation. The NMMG work programme includes reviewing and assessing the annual reports provided by each DHB as part of its MQSP. NMMG provides advice to the Ministry on priorities for national improvement, and provides advice to DHBs on priorities for local improvement.

They have released two annual reports (2012-2013; 2013-2014) summarising progress to date from a national and local DHB perspective.

3. New Zealand Maternity Standards

The New Zealand Maternity Standards were published in 2011, and are also a core component of the MQI. The Standards were developed with clinical and consumer experts from maternity sector, and provide guidance for the provision of equitable, safe and high-quality maternity services in New Zealand. Alongside the Maternity Clinical Indicators (see below), the Standards underpin a programme of ongoing systematic review by local multi-disciplinary teams.

The Standards consist of three high-level strategic statements to guide planning, funding, provision and monitoring of maternity services by the Ministry, DHBs, service providers and health practitioners. The Maternity Standards underpin the Primary Maternity Services Notice (2007), Maternity Referral Guidelines (see below), DHB maternity service specifications, and other high-level guidance. They are designed to complement existing legal and policy requirements in New Zealand.

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 as a normal life stage

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.

Audit criteria and measurements sit under each high-level standard to track progress – national and DHB level. Many of the measurements, at both national and local DHB levels, would be covered by a well-functioning national MQSP, and local MQSPs. Annual report guidance for local MQSPs provides an opportunity for MQSPs to demonstrate their fulfilment or achievement of specific expectations in the Maternity Standards.

4. New Zealand Maternity Clinical Indicators

The New Zealand Maternity Clinical Indicators were established in 2011 by an expert working group supported by the Ministry, and were initially a set of 12 indicators that could be measured by data available at the time. Reports are published annually on data against the maternity clinical indicators, with the first such report on 2009 maternity data published in 2012. 2010 data was reported on in 2012, 2011 data in 2013, and 2012 data in 2014. In 2013 the NMMG reviewed the original indicators and recommended changes, which were further reviewed and developed by the original expert working group.

The first year of data analysed in relation to the revised 15 indicators was 2012, from the latest report published during this evaluation period, in October 2014. Below are the current clinical indicators. These will be reviewed in 2015:

1. Registration with a Lead Maternity Carer
2. Type of birth: Spontaneous vaginal birth among standard primiparae

3. Type of birth: Instrumental vaginal birth among standard primiparae
4. Type of birth: Caesarean section among standard primiparae
5. Type of birth: Induction of labour among standard primiparae
6. Degree of damage to lower genital tract: Intact lower genital tract among standard primiparae giving birth vaginally
7. Degree of damage to lower genital tract: Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally
8. Degree of damage to lower genital tract: Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally
9. Degree of damage to lower genital tract: Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally
10. General anaesthetic for women giving birth by caesarean section
11. Blood transfusion during birth admission for caesarean section delivery
12. Blood transfusion during birth admission for vaginal birth
13. Severe maternal morbidity
14. Maternal tobacco use during postnatal period
15. Preterm birth

The Health Quality and Safety Commission use the clinical indicators data to provide an 'Atlas of Healthcare Variation' for maternity, which displays maps, graphs, tables and commentaries that highlight variations by geographic area in New Zealand in the provision and use of health services and health outcomes. MQSPs use Maternity Clinical Indicators data to plan and implement initiatives to drive quality improvement and improve maternity outcomes.

5. National Clinical Guidelines

In planning of the Maternity Quality Initiative, the expert working group developing the National Maternity Standards agreed there was a need to have nationally consistent clinical guidance for specific issues in the maternity sector. This was also recommended by PMMRC, the Health and Disability Commissioner and the Minister of Health. MQSPs are expected to comment on their DHB's implementation of national consensus clinical guidelines in their Annual Reports.

National Consensus Guideline for Treatment of Postpartum Haemorrhage (PPH)

The National Consensus Guideline for treatment of PPH was published by the Ministry in 2013, and is informed by a range of resources on the following topics:

- Assessing and arresting blood loss – estimating blood loss, uterotonics, carboprost, misoprostol, tranexamic acid, carbetocin, HemoCue© and coagulation clot lysis tests, uterine compression balloons, uterine packing gauze, stepwise devascularisation of the uterus / B-Lynch / brace sutures, fibrin glues and gel, artery ligation, hysterectomy.
- Minimising impact of blood loss and resuscitation – crystalloids and colloids, blood and blood products, recombinant factor VII (rFVIIa), aortic compression, intra-operative cell salvage (IOCS).

This guideline is also informed by other national and international guidelines and consensus statements, and DHB guidelines and policies.

Observation of Mother and Baby in the Immediate Postnatal Period: Consensus statements guiding practice

These consensus statements were developed by members of NZCOM and RANZCOG NZ Committee with support of the Ministry, and published in 2012. The guideline was reviewed by the Neonatal Encephalopathy working group of the PMMRC and endorsed by the Ministry and the National Maternity Guidelines Working Group. Implementation of this guideline is led by professional colleges, and included in every DHB's local MQSP.

The guideline outlines the responsibilities of practitioners, involvement of family and whānau, responsibilities of DHBs or employers, rationale for the guidelines, and definitions of what is included in ongoing assessment of mother and baby in the immediate postnatal and neonatal period, and a bibliography of resources that inform the consensus statements.

6. Maternity Referral Guidelines

The 2012 Maternity Referral Guidelines are revised guidelines for Consultation with Obstetric and Related Medical Services. The current version is based on the 2007 guidelines, which were reviewed and revised by an expert working group, and published by the Ministry in 2012. The guidelines are intended to be reviewed every five years, with the next review to be completed by December 2016. MQSPs are expected to report on their implementation of the guidelines, i.e. process for transfer of clinical responsibility, in their Annual Reports.

The Referral Guidelines are intended to:

- improve maternity care safety and quality,
- improve consistency of consultation, transfer and transport processes, give confidence to women, their families and whānau, and other practitioners if a primary health care or specialist consultation, or a transfer of clinical responsibility is required, and
- promote and support coordination of care across providers.

The guidelines are based on best practice and informed by available evidence, expert opinion and current circumstances in New Zealand. They are underpinned by eight guiding principles about the care of women, babies and families/whānau through pregnancy, birth and the postpartum period. Categories of referral include primary, consultation, transfer and emergency. Processes for referral for consultation and transfer of clinical responsibility outline considerations around timing and process maps for decision making. Roles and responsibilities must be taken into account, communication channels must be appropriate, and meeting local conditions is important.

7. National Maternity Consumer Survey

The National Maternity Consumer Survey is undertaken every three years. Previous consumer surveys were carried out in 1999, 2002 and 2007. The last maternity consumer survey report was published in 2012, which included results from women who had live births in July and August 2010 who participated in the survey in 2011. The 2012 report included separate results

from a consumer survey conducted with bereaved women, who lost a baby between 20 weeks of pregnancy and four weeks after birth. Consumers had previously given feedback on the importance of giving a voice to women who have lost their babies.

Questions are asked according to several themes that impact on consumer satisfaction with maternity care: care during the pregnancy, information sources, care during the birth, care during the hospital stay following the birth, care at home following the birth, and care received from a midwife.

The results from the 2011 maternity consumer satisfaction survey provided important information during the setup of local MQSPs in 2012. Another maternity consumer survey is currently taking place for women who gave birth in December 2013, January and February 2014 – over 10,000 women have been invited to take part. Consumer feedback and representation is an important part of local MQSPs, and MQSPs are advised to facilitate consumer input into their local programmes (some use local consumer surveys, for example). Consumer feedback is facilitated nationally through forums and the survey.

8. Improvements to information systems and reporting

The Ministry provides data from the National Maternity Collection (MAT) and reports analysis on their website. MAT contains data on primary maternity services provided under Section 88 of the New Zealand Public Health and Disability Act 2000 and also contains inpatient and day-patient health event data during pregnancy, birth and the postnatal period for mother and baby, sourced from the National Minimum Dataset (NMDS)—a national collection of public and private hospital discharge information. MAT was developed as an early priority of the Maternity Quality Initiative and went live in 2010.

The latest Report on Maternity, published in April 2015, provides analysis of data from 2012 when the national and local MQSPs were in their development and planning phase. The Report on Maternity series is intended to be annual, though the previous report was on births in 2010.

The Ministry also provides Maternity Data Tables in an excel format. These present a summary of the maternal and new-born information for all women with a known birth and act as an interim product prior to publication of a full annual report. The latest document, on births in 2012, was published in 2015. 2011 data was published in 2014.

The Ministry is continuing with a project to collect and integrate DHB primary maternity data into MAT. Progress has been slower than anticipated but continues.

The Maternity Information Systems Programme is a national project, started as part of the Maternity Quality Initiative. It combines three initiatives – the Maternity Clinical Information System project (MCIS), the shared maternity record view project and the maternity data set project. A fourth project as part of the Programme is being developed: a neonatal clinical information system for DHBs. MCIS is being progressively rolled out across all DHBs, with MidCentral, South Canterbury, Whanganui, Tairāwhiti and Counties Manukau DHBs being the first to sign on, with implementation beginning in October and November 2014. The next group of DHBs will begin rolling out the system in mid-2015. MCIS pulls together maternity information from the community (e.g. midwives, GPs) and the hospital (e.g. maternity ward), and will allow consumers and health professionals to view a summary of their maternity information through a secure website.