

ANNUAL REPORT 2014



National Maternity
Monitoring Group

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The National Maternity Monitoring Group welcomes comments and suggestions about this publication.

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Chair's Introduction



Over the past year, I have been delighted with the progress made in New Zealand's maternity sector. Not only are we seeing changes in how services are delivered to women, but we are also entering a new phase of collaboration.

With the National Maternity Monitoring Group (NMMG) regularly raising questions and seeking information, we have been able to spark an ongoing state of enquiry within the maternity sector. These requests are not being seen as negative by DHBs, GPs and other service providers - quite the opposite in fact. We are uncovering a genuine desire by all parties who provide maternity services to engage and contribute to finding new, improved ways of working together to improve the quality of maternity care for women and their babies.

This high level of interaction can be seen in many of the work streams we have continued with, or initiated, in 2014. You will see from this report that the information we have provided to DHBs in relation to variability in gestation at time of birth has been particularly robust, because of improved data capture by the DHBs. The NMMG has then been able to utilise that and ask questions of the DHBs. Their responses in this area in particular have generated some considerable debate, and we are encouraged by their openness and response to our requests for information about actions they have taken now they have that data.

The NMMG remit allows us to observe the sector in its entirety. The collective work by all members of the NMMG, together with the maternity sector, demonstrates the benefits of having specialist groups like this. Such a group is able to delve into information, asking questions about what may be occurring and about the evidence underpinning the data. This allows us to make recommendations for improvement. This year we have started to increase our focus on the monitoring role of the NMMG and identifying areas of weakness in the sector that need addressing. In this annual report, as we enter our third year, we have been much clearer about where we expect the Ministry of Health and DHBs to introduce changes.

The work of the members of the NMMG, through the framework of the Maternity Quality and Safety Programme (MQSP), are giving the maternity sector the focus it deserves. We now need the Ministry of Health and service providers to consider our findings, and through the MQSP and the wider quality frameworks in DHBs, consider how best to act on our recommendations. These discussions are also being initiated to ensure that the overview of the NMMG and the work within the MQSP has had three years of establishment funding and needs to now be incorporated within each DHBs' quality workstream. In this way we can continue to further strengthen the maternity system for New Zealand's women and babies.

With this plea for continued support and integration of the quality framework across the maternity sector, from policy development to service delivery and consumer groups, it is with great pride that I present the second annual report of the NMMG.

About the National Maternity Monitoring Group (NMMG)

The National Maternity Monitoring Group (NMMG) was established in 2012 by the New Zealand Ministry of Health (the Ministry). The Group's remit is to oversee the maternity system in general and, more specifically, the implementation of the New Zealand National Maternity Standards (2011)¹.

Ultimately, the NMMG acts as a strategic adviser to the Ministry on areas for improvement in the maternity sector. We provide a national overview of the quality and safety of New Zealand's maternity services.

This is our second full year of operation.

Background

The NMMG was created as part of the Maternity Quality Initiative, which is made up of:

- A national Maternity Quality and Safety Programme, including maternity standards and clinical indicators;
- Revised Maternity Referral Guidelines, which set out processes for transfer of care, including in an emergency;
- Standardised, electronic maternity information management to improve communication and sharing of health information among health practitioners, and
- Improved maternity information systems and analysis so that there is better reporting and monitoring of maternity services.

The New Zealand Maternity Standards, as part of the Maternity Quality and Safety Programme (MQSP), consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services:

- Standard 1: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies;
- Standard 2: Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage, and
- Standard 3: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

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

The National Maternity Monitoring Group's (NMMG) role is to provide advice to the Ministry on priorities for national improvement based on a number of key publications, and to provide advice to DHBs on priorities for local improvement. There are a number of more specific activities outlined in our Terms of Reference (please see Appendix One).

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

NMMG members

The NMMG consists of clinical sector experts and a consumer representative. Members have been brought together to represent different skill sets and expertise, covering areas such as midwifery, obstetrics, clinical research, primary care, obstetric anaesthesia, neonatal paediatrics and the perspective of service users. The members are:



Norma Campbell (Chair)

Norma is a Midwifery Advisor - Quality and Sector Liaison for the New Zealand College of Midwives and a member of the International Confederation of Midwives Council for the past six years. She has been involved in a number of expert advisory groups for maternity including developing and supporting the MQSP. She was the Chair of the National Breastfeeding Advisory Committee. Norma also practises as a casual core midwife at Lincoln Maternity Unit, Canterbury DHB.



John Tait (Vice-Chair)

John is a consultant obstetrician and New Zealand Councillor on the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. He is also the Executive Director Clinical Surgery, Women and Children's Directorate at Capital and Coast DHB. He works in public obstetric practice and privately in gynaecology and reproductive medicine. John has been involved in a number of expert advisory groups including developing and supporting the Maternity Quality and Safety Programme.



Beverley Lawton (Ngati Porou)

Beverley is the Director of the Women's Health Research Centre and an Associate Professor, University of Otago. She is a member of Te Ohu Rata O Aotearoa (Māori Medical Practitioners Association) and Te Akoranga a Maui (Māori faculty of the Royal New Zealand College of General Practitioners). Beverley is currently leading the national Severe Acute Maternal Morbidity research project, which is reviewing "near miss" maternity events.



Elaine Langton

Elaine is a specialist anaesthetist and, until recently, was the Clinical Leader of Obstetric Anaesthesia at Capital and Coast DHB. She is a member of the New Zealand Society of Anaesthetists and a fellow of the Australian and New Zealand College of Anaesthetists. She has specialised in obstetric anaesthesia for more than 20 years and has represented obstetric anaesthesia on a number of maternity advisory groups. Elaine is currently involved in the Severe Acute Maternal Morbidity research project, which is reviewing "near miss" maternity events.



Frank Bloomfield

Frank is a neonatal paediatrician at National Women's Health, Auckland City Hospital and Professor of Neonatology at the University of Auckland. He is currently President of the Perinatal Society of Australia and New Zealand and a corresponding member of the New Zealand Paediatric and Child Health Division Committee of the Royal Australasian College of Physicians. Frank also leads a large research group investigating perinatal care at the Liggins Institute, University of Auckland. He contributed to the Working Group on Maternity Standards.

NMMG members



Judith McAra-Couper

Judith is Chair of the Midwifery Council and the Head of Midwifery at Auckland University of Technology. Judith is an Associate Professor and Director of the centre for Midwifery and Women's Health Research and is involved in a number of research projects including maternal mental health, sustainability of midwifery practice and place of birth. Judith regularly works for the World Health Organisation in Bangladesh in Midwifery education. She has worked in Counties Manukau Health for many years and continues to be involved in this community.



Margret Norris

Margret is the Midwifery Leader for Bay of Plenty DHB. She has had various roles in the Midwifery Profession as an employed midwife working in the DHB and as a lead maternity carer (LMC) midwife working in the rural areas. Margret continues to be a practising midwife.



Rose Swindells

Rose is a mother with a passion for community development. Before having children she managed community centres in Wellington and family learning projects at historic sites in London. She is currently actively involved in the Wellington Time Bank and the Newtown Breastfeeding Support Centre and Houghton Valley Playcentre. Since she has become a mother she has enjoyed using her community networking and advocacy skills as a Consumer Representative on the Capital and Coast DHB's Maternity Quality and Safety Panel.



Sue Belgrave (ex officio)

Sue is the current Chair of the Perinatal and Maternal Mortality Review Committee (PMMRC). She is a consultant obstetrician and gynaecologist at North Shore and National Women's Hospitals; Clinical Director of Obstetrics, Waitemata DHB, and a private gynaecologist at Shore Women. She is a RANZCOG training supervisor and is the Chair of the Auckland training committee. Sue is a local coordinator at Waitemata for the PMMRC and is an advisor on ultrasound in Obstetrics and Gynaecology.



Bronwen Pelvin (ex officio)

Bronwen is the Ministry's Principal Advisor on Maternity. A midwife with more than 30 years of experience, Bronwen has worked as a domiciliary midwife, a community-based LMC, a core midwife and a maternity manager. She worked as the national Midwifery Advisor for the New Zealand College of Midwives and was also the Professional Midwifery Advisor for Nelson Marlborough DHB before moving into her current role.



ONZL (secretariat)

ONZL provides secretariat and support services to the NMMG. It works across a range of sectors including health, education, ICT and telecommunications. ONZL has extensive experience working with New Zealand industry associations and government departments to deliver their organisational goals by providing board and governance support, meeting facilitation, analysis services, project management, finance management and administrative support.





The NMMG Work Programme for 2013/14

Taking into account our remit and Terms of Reference, the 12-month work programme of the NMMG during 2013/14 included the following:

1. Continuing to review the **timing of registration with a Lead Maternity Carer (LMC)** and particularly how to increase the proportion of women who register with an LMC before 12 weeks' gestation;
2. Assessing **variation in gestation at birth** across New Zealand;
3. Understanding national consistency in the provision of **coordinated maternal mental health services**;
4. Reviewing national variability in the access to, and quality of, **primary maternity ultrasounds**;
5. Aiming to better **connect and support maternity consumer representatives**;
6. Reviewing and advising on the **New Zealand Maternity Clinical Indicators**;
7. Reviewing the Ministry of Health **Annual Report on Maternity**;
8. Reviewing, and potentially providing expert advice on, the DHB **Maternity Quality and Safety Programme (MQSP) annual reports**, including their progress since the previous year's reports, and
9. Production of an **NMMG Annual Report**.

In this report we outline our findings and recommendations relating to this year's work programme. A number of supporting documents can be found in the appendices, including a table illustrating the work programme (Appendix Two). A map of New Zealand DHBs can also be seen in Appendix Three.

An Overview of NMMG Recommendations

There are a number of things that must happen to ensure improvements are made in the provision of maternity services in New Zealand. Below we have outlined those areas where we expect action from key maternity stakeholders:

- **Registration with an LMC** - we want to see continued focus on first trimester registration and expect to see clear outcomes from relevant initiatives over the coming year. To ensure national consistency, specific cultural needs must be met and it is essential that DHBs support and improve relationships between LMCs and GPs;
- **Variation in Gestation at Birth** - we want rates of induction of labour and caesarean sections to be monitored carefully by DHBs and progress fed through to the NMMG. It is essential that health care providers, DHBs and other stakeholders use consistent terminology;
- **National Consistency in Provision of Coordinated Maternal Mental Health Services** - each DHB must include a formal maternal mental health referral pathway in its next MQSP annual report;
- **Maternity Ultrasounds** - we want more effort from professionals, the Ministry and DHBs to understand and act on the rising number of primary ultrasound scans. This is a priority for the NMMG;
- **Connecting and Supporting Maternity Consumer Representatives** - support for consumer representatives is lacking. DHBs and the Ministry have a role in addressing this. Support must include role clarification, financial reimbursement, access to their community, proper mechanisms to report into the MQSP and opportunities to connect at the national level;
- **The New Zealand Maternity Clinical Indicators** - clinical maternity coders are under-supported which is hampering national consistency. The Ministry and the DHBs must address this;
- **Ministry of Health Annual Report on Maternity** - this report is valuable and must be presented annually. We recommended a number of areas for improvement last year, and
- **District Health Board Maternity Quality and Safety Programme Annual Reports** - work to improve the quality of maternity services needs to be aligned with wider quality initiatives at the DHB level.

We also expect continued action in many of the areas covered in the NMMG 2013 Annual Report. This includes:

The 2012 Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) - clinical leadership and integration between community maternity service provision and maternity facilities must be discussed in DHBs so that the Referral Guidelines can be properly implemented

Smoking among pregnant women - the Ministry should consider requiring PHOs to record and report on the smoking cessation (ABC) advice given to pregnant women in their general practices.

You can read more details of all these recommendations in the appropriate sections of this annual report.

The Second Annual Report of the National Maternity Monitoring Group

Over the following pages we outline our work over the year 2013/14. We talk about our remit, findings and give areas for improvement. We also share examples of good practice and useful statistics.



Registration with a Lead Maternity Carer

Our focus

To investigate the timing of registration with Lead Maternity Carers (LMCs), paying particular attention to those women not registering before 12 weeks' gestation. We selected a 12 week cut-off as this signifies the end of the first trimester and the data capture for this period can be obtained through the National Maternity Collection as a result of claims against the Section 88 Notice. In addition, we wanted to explore how each DHB might improve the level of, and access to, LMC registration.

We began our work in this area in 2012. We originally chose this work stream to reflect a recommendation discussed in the Sixth Annual Report of the PMMRC². On page six of that report, it was identified that:

“All women should commence maternity care before 10 weeks, which enables:

- Opportunity to offer screening for congenital abnormalities, sexually transmitted infections, family violence and maternal mental health, with referral as appropriate;*
- Education around nutrition, smoking, alcohol and drug use, and other at-risk behaviour;*
- Recognition of underlying medical conditions, with referral to secondary care as appropriate, and*
- Identification of at-risk women (maternal age, obesity, maternal mental health problems, multiple pregnancy, socioeconomic deprivation, maternal medical conditions).”*

Additionally, in 2013 a House of Representatives Health Committee Report titled 'Inquiry into improving child health outcomes and preventing child abuse, with a focus from preconception until three years of age'³ gave a number of recommendations that relate to this work stream, including:

“That the Ministry of Health require district health boards to set a key performance indicator for the majority of women to be booked in for antenatal assessment by 10 weeks' gestation. Best-practice clinical, social, and laboratory assessment should take place, and an ongoing plan for the pregnancy formulated.”

We continue to focus on this work stream because it is important. All parties within maternity need to continue to educate women about the need to connect with a health professional in the first trimester of pregnancy. The aim of registering early is to commence the relationship of antenatal engagement, enabling ongoing monitoring and support to be provided for the pregnancy. Public health messages can also be conveyed at this early stage. For this to occur, women themselves need to understand the importance of registering with an LMC early and to experience and see value in doing so for the health of both themselves and their baby.

² Perinatal and Maternal Mortality Review Committee. 2012. Sixth Annual Report of the Perinatal and Maternal Mortality Review Committee. Wellington: Health Quality and Safety Commission.

³ Health Committee. 2013. Inquiry into improving child health outcomes and preventing child abuse, with a focus from preconception until three years of age. Wellington: New Zealand House of Representatives.

What we've done this year

We assessed data from the National Maternity Collection (2013). We looked specifically at the number and percentage of women registered with an LMC by the end of the first trimester, where the year of birth was 2012, in comparison to 2011. The data was organised by DHB of domicile and was the most current data available at the time.

This data only includes women who have an LMC registration reported and funded under Section 88 of the New Zealand Public Health and Disability Act 2000. Women who receive their primary maternity care from DHB-funded primary maternity teams are not included. DHB primary maternity care data collection is underway but is not yet complete enough for analysis.

Having reviewed the data, we then shared it with each DHB. This helped each DHB's Maternity Quality and Safety programme see whether the number of women in their region registering with an LMC during the first trimester in 2012 had improved or was similar to 2011. We also asked for information on:

- How they intend to improve the number of women registering with an LMC in the first trimester in their region;
- Whether their DHB had considered the recommendations made by the NMMG in the annual report 2012/13;
- How they intend to engage with providers and local women to understand expectations and service provision in the first trimester;
- How they ensure the LMC services in their area are culturally appropriate for different groups, and
- If they book women through a DHB primary maternity team, what is their DHB's policy around gestation of booking.

Many women use non-LMC maternity services in the first trimester and we were keen to capture this data too. Non-LMC maternity services are services that are either in addition to lead maternity care, or represent services sought on a casual basis, mainly through general practice.

They must be provided free of charge to women who are eligible to receive them. In order to claim for this service, providers must fulfil a number of criteria, including informing the woman about her options for choosing an LMC.

To capture data on non-LMC maternity services, we looked at the volumes of non-LMC first trimester claims by registered DHB region of practitioner, by year of claim. This data helped us understand the pathway some women follow to register with an LMC in each DHB.

What we found

Non-LMC antenatal care

We were surprised at the high numbers of non-LMC first trimester claims that we found. In 2012, there were 49,015 non-LMC claims nationwide, which equates to 79% of the total births in that year. Non-LMC first trimester services can only be claimed once per woman per pregnancy, showing a large proportion of women receive non-LMC care before they register with an LMC.

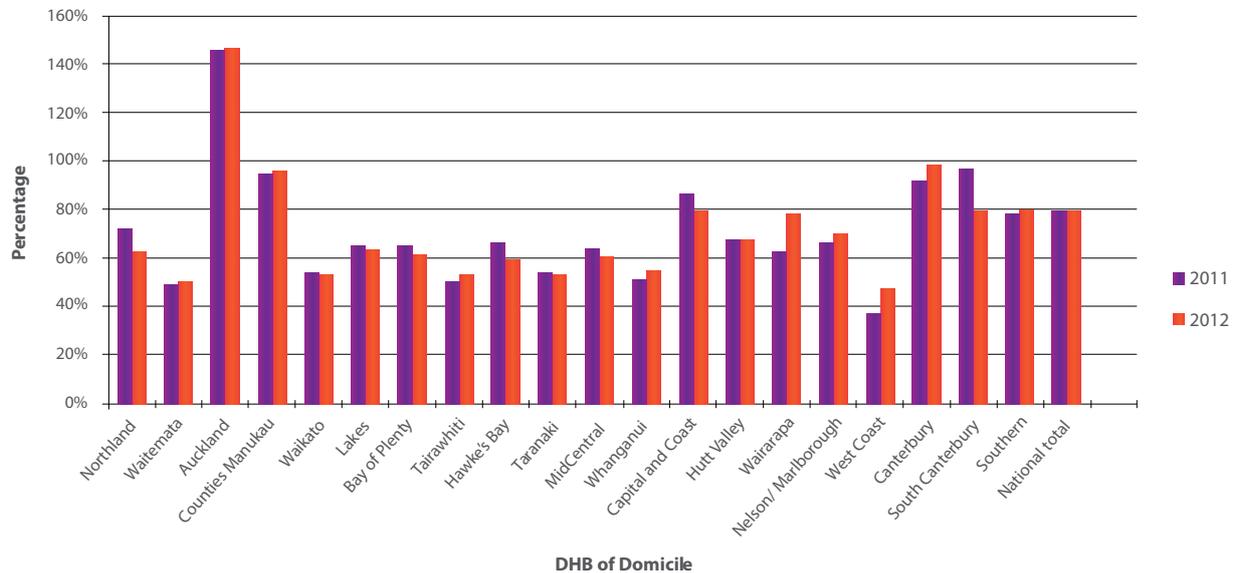
Registration with an LMC - 2011 compared to 2012

Between 2011 and 2012 there was little change in the statistics for LMC registration. Nationally, in 2012, only 64% of women registered with an LMC within the first trimester. This is only slightly higher than in 2011 where it was 63%.

In 2012, the proportion of women registered in the first trimester ranged from 41% to 74% around the country, very similar to the range in 2011 (42% to 74%).

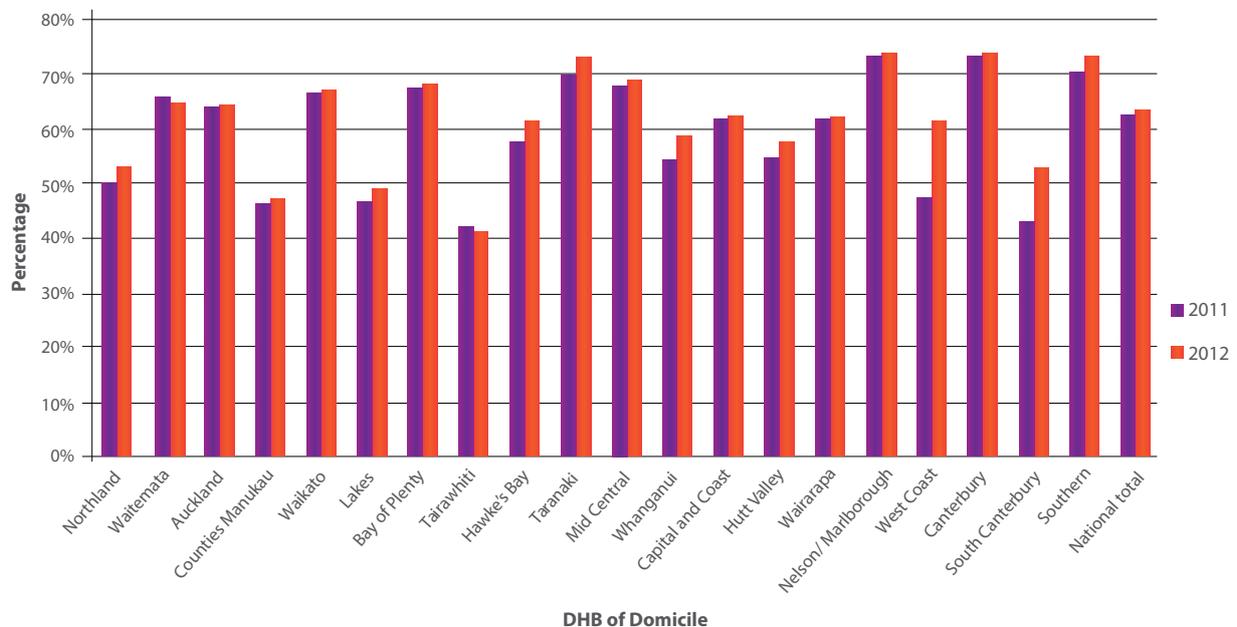
Whilst the number who registered with an LMC in the first trimester had not changed significantly since the last report, the number of women who saw a non-LMC health practitioner in the first trimester was higher than we expected. Whilst there are contractual expectations in relation to the service provided in order to make this claim, this has raised further questions by the NMMG in relation to the quality of the service these women receive at this contact when they are first pregnant and whether it fulfils what is required in the first trimester, including registering with a Lead Maternity Carer.

Percentage of Non-LMC claims, by DHB of Domicile, 2011 & 2012



Source: National Maternity Collection (2012 and 2013) Note: Claims include services claimed for women who do not go on to appear in the births dataset (miscarriage/TOP/left NZ); therefore, the denominator (births) does not include some women who appear in the numerator. These should, therefore, not be considered absolute but as a reasonable starting point for comparisons amongst DHBs. The numerator represents practitioner domicile while the denominator represents women's domicile, therefore numbers for adjoining urban DHBs such as Auckland & Waitemata are likely to represent significant inter-district flows. These numbers should be interpreted with caution.

Percentage of Women Registered with an LMC in the First Trimester, by DHB of Domicile, 2011 & 2012



Source: National Maternity Collection (2012 and 2013)

In 2013 we recommended...

In our 2013 annual report, we requested that DHBs focus on increasing first trimester LMC registration rates. In particular, we strongly recommended that:

1. DHBs consider new ways to encourage women to register in the first trimester by understanding the needs, demographics and distribution of the women in their DHB who are becoming pregnant.
2. Each DHB should:
 - Consider their pregnant population more fully;
 - Reduce barriers and improve access to appropriate services, and
 - Support the use of the Find Your Midwife website in general practice.

What has changed since then?

Most DHBs noted that they had given serious consideration to the NMMG's recommendations or had made early registration with an LMC a priority of their MQSP. Some noted that this topic would be explored in their next MQSP annual report. There appears to be a greater focus by many DHBs on supporting the work of LMCs by encouraging women to register early. We found a number of good steps were being taken.

Initiatives to improve the number of women registering with an LMC in the first trimester

We found many different initiatives were being used by DHBs to work within their community with women, and also LMCs, to improve the timing of registration with an LMC in their area. They included:

Information

A number of DHBs discussed plans to improve communication with consumers and other health care providers about early booking with an LMC. Initiatives included:

- Facebook pages;
- Websites like the NZ College of Midwives's Find Your Midwife site and Mamaternity;
- Regional-specific Health Pathways sites;
- Links to the NZ College of Midwives website and Healthpoint, and
- Promotional material placed with other providers such as general practices, schools, and on contraception packs provided by youth services.

New models of information sharing

Many DHBs plan to implement different models for the provision of maternity information and options for care in the first trimester. The main idea that came through was a walk-in-centre, which provided information, provided pregnancy diagnosis, booked women in with an LMC and had a space where women could meet with an LMC (without an appointment).

Some DHBs have tried to increase the visibility of these centres, if they already have them in place. One DHB has a free 0800 number at this service and reports that this has been helpful in removing the cost barrier for women wanting to call them to make an appointment or receive advice. Other initiatives included increasing midwives' presence at general practitioner (GP) clinics, and having a midwife who liaises with schools in the area.

Liaising with LMCs

Many of the DHBs noted that they have encouraged LMCs to book women earlier. They have also talked to them about the importance of documenting first engagement with women. However, we received no further information on how they did this.

Information gathering

A few of the DHBs that responded to the NMMG have started to pay more attention to this information and have started to monitor early registration and factors influencing it through local MQSP discussions.

Engagement with providers and consumers to understand expectations

Most of the DHBs planned to engage with consumers and community providers through their MQSP governance groups, or working groups of these governance groups.

Relationships with GPs

Many DHBs are building relationships with GPs and Primary Health Organisations (PHOs). Some DHBs have developed promotional material for GPs, or are promoting regional-specific Health Pathways for GPs to use. One DHB held an LMC/ GP workshop.

Another DHB noted that some GPs delay referring to LMCs until the second trimester. They plan to address this problem with the two PHOs in the region.

Consumers

Some of the DHBs have carried out (or plan to carry out) a survey with women who booked late, asking about barriers to booking. They plan to use the results of this to inform suitable strategies. Some of the DHBs have targeted these surveys at specific sub-groups such as Māori and Pasifika women.

The cultural appropriateness of maternity services

In some DHBs, relationships with the local iwi were strong. The iwi had input on the DHB's MQSP. One DHB uses the Health Equity Assessment Tool (HEAT) as part of their MQSP to identify cultural barriers to service access and health equity issues in their area. A few DHBs also plan to run targeted awareness campaigns on the importance of early booking. Others are carrying out surveys on barriers to booking amongst vulnerable populations.

Booking through DHB hospital teams - policies around gestation

DHB responses showed that booking through a DHB hospital team varies significantly across New Zealand. Most DHBs book a small number of women who come to them in early pregnancy because they don't have a GP, require interpreter services and/or have complex health/social issues. These DHBs noted they do try to find an LMC for the woman. The one or two DHBs that do provide more primary maternity services do so because they have workforce issues in the community, resulting in limited access to LMCs. This is expected to change over time as the midwifery workforce numbers have increased substantially over the past five years.

The changes we expect to see next

1. The Ministry and the various maternity professional colleges should continue to focus on the quality of care women receive from any care provider when they make contact in the first trimester. What should be provided/ offered to women is well-described currently. Within their MQSPs, DHBs should work with providers of first trimester maternity services and their local population to ensure that women understand what to expect and how to access services.
2. The NMMG expects DHBs to share any of the initiatives to improve first trimester registration rates and quality improvement outcomes to be noted by the MQSP in each DHB in the coming year. We will be following up with DHBs on the initiatives they have noted in their annual reports for 2013-14.
3. The NMMG expects all women to receive nationally consistent maternity care in the first trimester as described in the funding schedules, irrespective of who is providing it.
4. DHBs must continue to promote timely access to care in the first trimester including registration with an LMC. Information in this report and the MQSP reports published in each DHB can help establish new initiatives that support women to achieve this. In particular, we expect DHBs to continue to work with their local professional representatives to support relationships between GPs and LMC midwives in their region. This will assist the development of consistent pathways between services when women are first pregnant.
5. DHBs must work with all providers of maternity services to ensure that specific cultural needs, including those of Māori and Pasifika women are addressed through the local service provision model.
6. General practice must consistently provide a quality first trimester consultation as described in the funding schedule for first trimester. Importantly they must also help women to navigate into the maternity system and register with an LMC. We expect DHBs to offer support both for LMC midwives and general practices to help improve these rates.
7. The NMMG will continue to monitor this in the next year and will look at timeliness of this visit and the quality of the service that women receive in the first trimester and whether it meets the agreed expectations of this visit.

Good examples of promoting timely LMC registration

Whanganui, MidCentral and Capital and Coast DHBs

Whanganui, MidCentral and Capital and Coast DHBs have introduced a number of initiatives to promote early registration with an LMC in their areas.

One of these is the 'Pregnant: 5 things to do within the first 10 weeks' initiative. This campaign promotes the five things pregnant women should do in the first 10 weeks of pregnancy. These five things are:

1. Find an LMC;
2. Consider early pregnancy screening;
3. Take iodine and continue folic acid;
4. Eat well and exercise, and
5. Avoid smoking, drinking and other drugs.

Women are given details of relevant websites and 0800 phone numbers for contacting an LMC.

This initiative has been advertised in a variety of ways throughout these regions. This includes presentations to GPs, Well Child Providers and other providers involved with child health. Flyers have been published in local newspapers and a 'back of a bus' promotion has also been run. The information in each method has been altered slightly to reflect the needs of different communities. Some DHBs are currently also developing multi-language posters in both Te Reo and the five local Pasifika languages. The posters will be distributed to agencies in the community.

A number of other DHBs have now begun using this initiative.



Variation in Gestation at Birth

Our focus

This work stream reflects the NMMG's role in overseeing the implementation of Standard 1 of the National Maternity Standards, particularly to ensure that maternity services achieve "optimal health outcomes for mothers and babies".

The NMMG focused on preterm births (prior to 37 completed weeks' gestation) in New Zealand in 2012/13. This year, we decided to focus on variation in gestation of term births 37-40 weeks.

Research shows that worldwide there have been increases in planned early term birth. We noted in our last report that late preterm births (births between 34 and 36 weeks' gestation) may be increasing in New Zealand. This may be related to changes in obstetric decision-making⁴ and changes in planned or elective early births. However, prolonging pregnancy generally results in better neonatal outcomes and less health resource use with each week gained in gestational age.^{3,5,6}

We wanted to understand any variations in gestation at birth that are occurring between DHBs, and what the DHBs themselves consider to be the reasons for these differences.

What we've done this year

We were particularly keen to look at the impact of obstetric decision-making on variation in gestation at birth. This was because obstetric decision-making is an area that could potentially be changed.

Using information sourced from the National Maternity Collection in 2014, we assessed the number of elective caesarean deliveries and inductions of labour at each hospital in New Zealand, as a percentage of total births at that hospital, at 37, 38 and 39 weeks' gestation, from 2009 to 2012. If a single pregnancy resulted in multiple births (twins, etc.), it was counted once.

The NMMG sent this information, and background to this issue, to every DHB. We asked for their comments on this information, including why they thought these trends were occurring over time. This issue was also raised with MQSP coordinators in most regions.

We also looked at international changes to terminology regarding this period of gestation. International evidence suggests that classifying 'term' gestation as early term (37-38 weeks), full term (39-40 weeks), late term (41 weeks) and post term (42+ weeks) may positively promote consistent obstetric decision-making⁷.

What we found

Elective caesareans

We noted there was significant variation in the rates of elective caesarean sections being performed by DHBs in New Zealand in 2012 at 37, 38 and 39 weeks' gestation.

Induction of Labour

There was also significant variation in the rates of induction of labour in DHBs in New Zealand in 2012 at 37, 38 and 39 weeks' gestation.

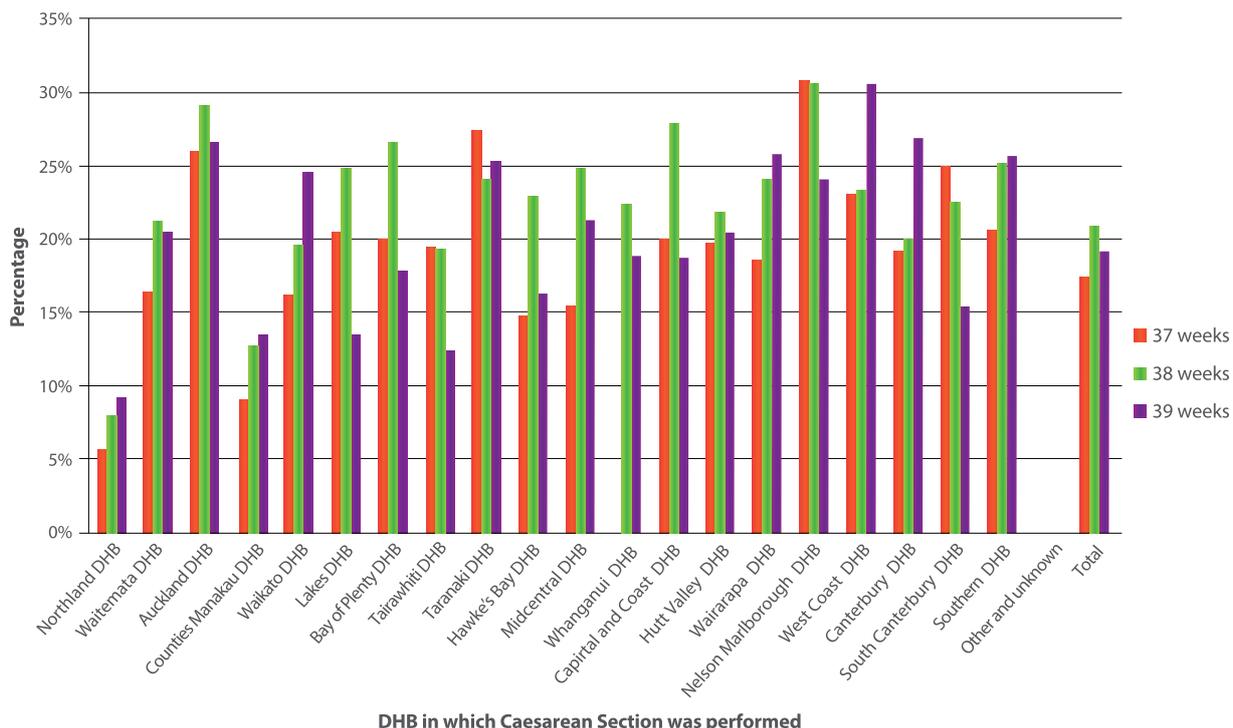
⁴ Morris, J.M., Algert, C.S., Falster, M.O., Fod, J.B., Kinnear, A., Nicholl, M.C. & Roberts, C.L. 2012. Trends in planned early birth: a population-based study. *American Journal of Obstetrics and Gynecology*, 207 (186), pp1-8. doi: 0002-9378/\$36.00

⁵ Boyle, E.M., Poulsen, G., Field, D.J., Kurinczuk, J.J., Alfirevic, Z. & Quigley, M.A. 2012. Effects of gestational age at birth on health outcomes at 3 and 5 years of age: population based cohort study. *British Medical Journal*, 344, e896. doi: 10.1136/bmj.e896.

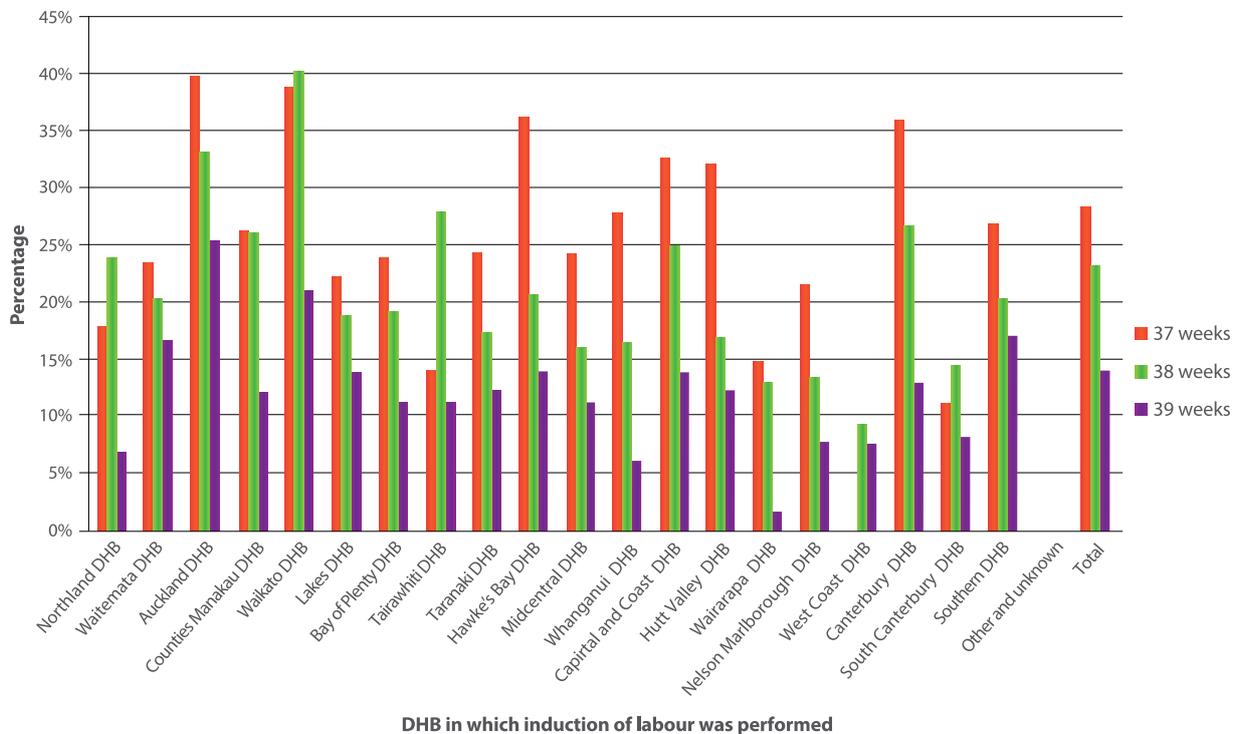
⁶ McLaurin, K.K., Hall, C.B., Jackson, E.A., Owens, O.V. & Mahadevia, P.J. 2009. Persistence of Morbidity and Cost Differences Between Late-Preterm and Term Infants During the First Year of Life. *Pediatrics*, 123(2), pp653-659. doi:10.1542/peds.2008-1439.

⁷ American College of Obstetricians and Gynecologists. 2013. Definition of term pregnancy. Committee Opinion No. 579. *Obstetric Gynecology*, 122 (579), 1139-40. ISSN 1074-861X.

Elective caesarean deliveries as a percentage of total deliveries in each DHB at 37-39 weeks' gestation, 2012



Induction of labour performed as a percentage of total deliveries in each DHB at 37-39 weeks' gestation, 2012



Source: National Maternity Collection (2014)

In 2013 we recommended...

Last year, we focused on preterm births. While this focus has changed to variation in gestation at term birth this year, our recommendations are still relevant. In 2013 we requested that:

1. All DHBs audit preterm births in their region, particularly births at 34, 35 and 36 weeks.
2. Factors that can be changed may include elective or planned deliveries and the clinical reasons for these.
3. Every DHB should cover the subject of preterm births in its next MQSP Annual Report. This should include information about interventions that have occurred as a result of information contained in the NMMG report in relation to late preterm births.

What has changed since then?

We were impressed by the quality of comments from DHBs on the information we provided about births at 37, 38 or 39 weeks and preterm births. Some noted that they had already focused on preterm births following the publication of the 2013 NMMG Annual Report and that this additional information provided further value for them to consider clinical decision making and rationale for births occurring at these gestations, either by elective caesarean or following induction. The information we received included:

Reasons for trends in their region

Many DHBs assured the NMMG that increases in their region for early term caesarean sections and inductions of labour are in accordance with best practice guidelines but that it did make them review and consider this from a quality perspective.

Demographic changes

It was noted by some that increases are due to changes in demographics at birth e.g. older mothers and associated risk, as opposed to obstetric decision-making. This needs to be debated further in relation to evidence⁸.

Clinical evidence

Some noted that increased caesarean sections and inductions performed at early term (37-38 weeks' gestation) may be due to better clinical evidence regarding when these should be done for specific clinical cases. (For example, increased awareness of the importance of antenatal recognition of Small for Gestational Age babies and, for expedited delivery, if there is a risk to the baby.)

VBAC

Others noted that this increase has been due to a decrease in Vaginal Birth after Caesarean (VBAC). They believe this is an area where more education and consensus is required between professionals but also in relation to information for women to consider VBAC.

Ultrasounds and GROW charts

Some DHBs noticed that increases in inductions of labour may link to increases in ultrasounds performed and subsequent plotting on Gestation Related Optimal Weight charts. This links to the ultrasound work stream of the NMMG (see page 26).



⁸American College of Obstetricians and Gynecologists. 2014. Safe prevention of the primary cesarean delivery. American Journal of Obstetrics and Gynecology, Obstetric Care Consensus No. 1(123), 693-711. https://www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery.

Information

Some DHBs provided additional information they had collected. A few noted that there had been little increase in the number of early term babies born, particularly from caesarean sections or inductions of labour, in their region. This differed from the information provided to them by the NMMG, prompting them to review data sent to the Ministry of Health. Other DHBs showed that clinical reasons supported the increase in their area.

Work that DHBs plan to do

Most DHBs noted that further investigation and analysis of data relating to increasing rates of induction of labour and caesarean sections needs to be undertaken to inform their practitioners, services and policies. They noted the information provided by the NMMG had allowed them to identify specific areas that need further investigation. This may include clinical audit to look at preterm birth rates by gestation (also broken down by an obstetric team) and adherence to clinical policies. Some plan to do this as part of the MQSP 2014-15 work plan.

Some DHBs also told us that they now plan to review, and possibly alter, their model of care regarding induction of labour and caesarean sections. This may include consulting with stakeholders through their MQSP governance group. As a result of information provided to the DHBs on this topic some have already put in place policies to undertake elective caesarean sections and induction of labour at full term if there is no fetal or maternal compromise.

The NMMG would like to congratulate those DHBs that have been so responsive on this topic and have already initiated quality frameworks around this issue based on current evidence.

The changes we expect to see next

1. We want all DHBs to continue to audit and review their data in relation to variation in gestation and monitor their rates of induction of labour and caesarean sections to ensure that babies are born at the most appropriate time.
2. To more accurately describe and review births occurring at or beyond 37 weeks' gestation to ensure that decisions that precipitate the delivery of babies are based on evidence and all inductions of labour and caesarean sections are reviewed with this in mind. We also expect health care providers, DHBs and other stakeholders to use consistent terminology to assist comparisons nationally:
 - 'Early term' = 37-38 weeks' gestation
 - 'Full term' = 39-40 weeks' gestation
 - 'Late term' = 41 weeks' gestation
 - 'Post term' = 42+ weeks' gestation

The NMMG will continue to monitor variation in gestation in 2014/15. We are looking forward to hearing about the progress of changes proposed by individual DHBs in communications to the NMMG.

Good examples of investigating variation in gestation

Capital and Coast DHB

Capital and Coast DHB were provided with information from the NMMG regarding elective caesarean and induction of labour rates in their region. In response to this information, they held a multidisciplinary clinical teaching session regarding elective caesareans. This stressed to staff the clinical risk and associated morbidity of late preterm births. A directive was subsequently issued across the DHB to ensure that the majority of elective caesarean sections are performed at or after 39 weeks' gestation.

As a result of the NMMG's information relating to induction of labour, a prospective clinical audit is underway looking at the DHB's induction of labour rates in standard primiparous women. The aim of this is to determine accurately the induction of labour rates in this group of women, monitor adherence to the induction of labour policy, and determine whether or not inductions are commencing based on accurate dating.

Bay of Plenty DHB

Following the publication of the 2013 NMMG Annual Report and the NMMG's 2014 letter to DHBs regarding variation in gestation, the Bay of Plenty DHB has placed a strong focus on this topic. They wish to better understand the underlying contributing factors that might be linked to clinical decision-making around the elective or planned time of delivery.

Recently, they have implemented changes to clinical practice in the DHB around the delivery of twins and induction of labour. They are also currently in consultation with maternity service providers to suggest ways to improve the variation in gestation in their region. They are also using their MQSP governance group to discuss, and possibly update, their policies and protocols around elective or planned deliveries and the clinical reasons for these.

National Consistency in Provision of Coordinated Maternal Mental Health Services

Our focus

To investigate national consistency in the provision of coordinated maternal mental health services. We want to ensure there is a coordinated pathway for women to follow between community practitioners and access to maternal mental health services and that good knowledge about this pathway exists within the maternity sector in each DHB.

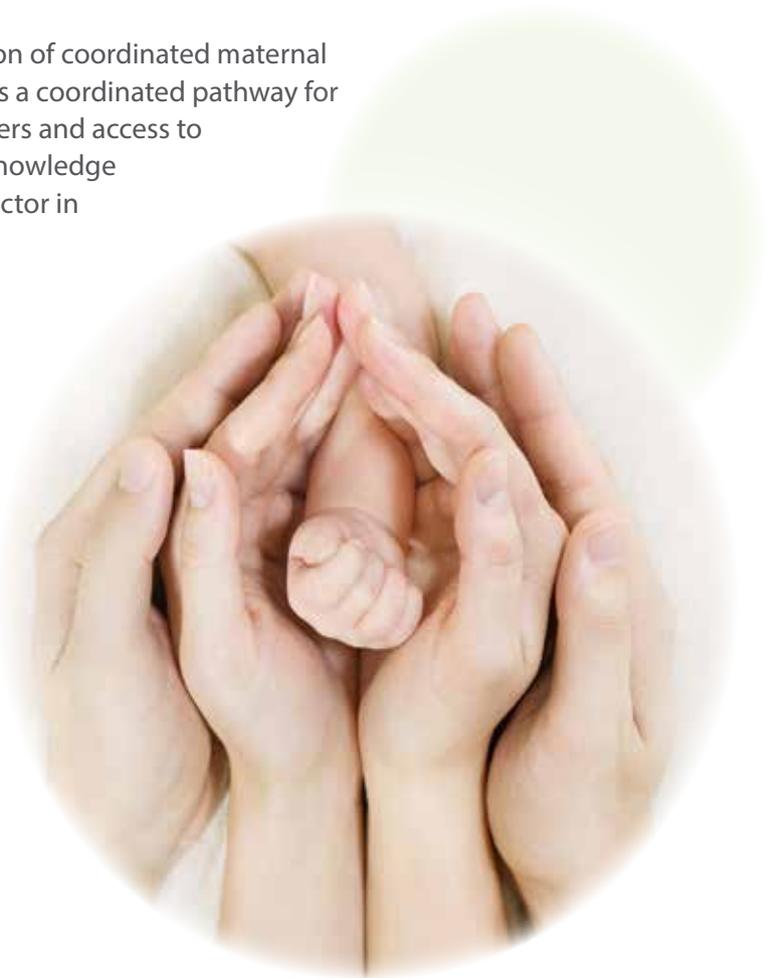
The availability and provision of mental health services to women who need it, during and after pregnancy, is essential for their safety and that of their babies. Women with existing mental health issues are at risk of escalation during the pregnancy and postnatal period. This is particularly true for women with a history of bipolar disorder, psychosis or postnatal depression/severe depression.

All DHBs are required, under the DHB Service Coverage Schedule, to provide perinatal and maternal mental health services. The 2013/14 DHB Service Coverage Schedule stated that:

“All DHBs will provide perinatal and maternal mental health service by direct provision of specialist services, through trained staff in generic adult Mental Health services or by access to regional specialist services... Women who are identified as needing mental health services when pregnant or in the period after birth will be able to access appropriate services to meet their needs and keep themselves and their babies safe.”

The Sixth Annual Report of the PMMRC also recommended that those working in the maternity sector screen women antenatally in order to identify women who are at increased risk of mental illness. It also recommended that there be better integration of maternal mental health services into maternity services.

In 2012/13, the NMMG reviewed the national consistency of maternal mental health services. This year we wish to continue this focus by: supporting better knowledge in the maternity sector of the mental health services available; improved timeliness of access for women, and better integration between maternity and mental health services.



What we've done this year

We liaised with the Ministry to understand current work on maternal mental health and how the NMMG can support it. We were particularly interested in: funding for primary maternal mental health services, the expectations attached to this funding, and national consistency in access to primary mental health services for pregnant women.

We then wrote to each DHB and asked them:

- Whether the DHB had considered the recommendations made in the 2013 NMMG Annual Report in relation to maternal mental health;
- Who was responsible for coordinating integrated maternal mental health services (primary and secondary) in their region, including between primary care, secondary care, maternity services and paediatric services, and
- What the pathway was between these services.

What we found

Primary mental health services

We found that current funding for primary mental health services is not ring-fenced. Instead it is part of DHB baseline funding, which is then transferred to PHOs. Recently there has been an increase in this funding, which is mostly targeted at youth mental health, low income groups, Māori, and Pasifika groups.

We also found that there is a lack of integration with secondary care mental health services to support the pathway into primary care, or from primary to secondary care. Promoting integration seems to have worked best in areas with strong clinical leadership.

What we recommended in 2013

Last year the NMMG focused on maternal mental health services at every level of care. We recommended that:

1. All DHBs promote access to services for women with maternal mental health issues. This will require better linkages between these services and maternity care providers.
2. Knowledge of mental health services available to the maternity sector must improve.
3. DHBs must provide the maternity sector in their area with clearer information on the mental health services available and enable direct referrals.
4. DHBs must link mental health services into their MQSP.
5. The Ministry must support DHBs in this work.

What has changed since then?

We received a good level of information from DHBs on maternal mental health services. Responses included:

Consideration of NMMG 2013 Annual Report recommendations

We were pleased to note that many DHBs had considered the recommendations of the NMMG and had carried out a number of actions as a result. This included actions to improve knowledge of mental health services among the maternity sector in their region, such as:

- Reviewing services in their region;
- Compiling a directory of services available and circulating this to LMCs and primary care providers in the region;
- Holding midwifery practice days or workshops with specific sections on maternal mental health and services available;
- Holding multidisciplinary meetings to discuss mental health services available for pregnant women;
- Inviting a mental health services representative onto their MQSP group;
- Appointing a midwife liaison to improve communication between LMCs and DHB staff, and
- Having information brochures for women on maternal mental health services in their community available throughout maternity services.

Responsibility for coordinating integrated maternal mental health services in each region

Many of the DHBs had either a person or team responsible for coordinating mental health services in their region, some specifically for maternal mental health. Some DHBs have received very positive feedback on the impact of this role in improving ease of access for women. Of those DHBs who did not, many noted that they would like to have this capacity.

One DHB noted that their coordinator aims to ensure that services are integrated across all maternity care providers. This allows women to step up and down the continuum of care as required, and practitioners to understand this process; including how women can access the services they need in a timely manner.

Pathways between maternal mental health and maternity services

We were very impressed to find that most DHBs either already have a specific pathway between services, or plan to formulate one. Pathways already in operation were made available to all staff in the DHB region including LMCs, sometimes using an online site. Often this pathway goes alongside a guideline for providers and patient information resources. Of those that plan to implement a pathway, most noted that they would do so as part of their 2014-15 MQSP work.

Some DHBs have used the process of developing and implementing a pathway to facilitate improved communication on this topic between health care providers in their region.

We were pleased to note that Capital and Coast DHB plans to adopt a referral pathway this year similar to the Taranaki DHB referral pathway, which was profiled in the 2013 NMMG Annual Report.

One DHB also plans to hold a maternal mental health forum, which hopefully will provide professional support to LMCs on specific cases and promote coordination of services.

Another DHB noted that they would like to be able to focus more on mild to moderate mental health issues in their region. They noted that this was made more difficult because service provision and funding streams appear to be siloed in their region.

Linking mental health services in MQSP annual reports

As part of our work stream on the MQSP draft annual reports, we also considered whether DHBs had discussed coordinated maternal mental health in their annual reports. We expected that, given this was a 2013 NMMG work stream and we had written to DHBs on this topic more than once, DHBs would have commented on this topic. We were disappointed to see that this had not occurred, despite the importance on maternal mental health in relation to maternal mortality.

Overall there was very little focus on this topic in 2013/14 MQSP annual reports. Whilst we received good information on the excellent work occurring in DHBs in response to our questions, this had not carried through to MQSP annual reports. There was a noticeable absence of any information regarding the maternal mental health pathway in these reports. This led the NMMG to then consider the source of information it received in relation to the maternal mental health work that is occurring. It would appear that there is a disconnect between this work within mental health in DHBs and those working in maternity, who appear to be unaware of it.

The changes we expect to see next

1. There is funding, albeit not ring-fenced, for maternal mental health services that has been allocated to PHOs for service provision. We therefore expect each DHB to work with PHOs to draft a formal maternal mental health referral pathway, which extends from conception until the child is one year old, and which integrates maternity and maternal mental health services, both in the community and for inpatient maternal mental health service provision.
2. Each DHB must include this pathway as part of its next MQSP annual report, and ensure that this pathway can be accessed by LMCs in their region.
3. We also recommend that within the MQSP work, DHBs consider how best to inform women about access to maternal mental health services.

Good examples of promoting maternal mental health

Nelson Marlborough DHB

Nelson Marlborough DHB reviewed the recommendations from the NMMG's 2013 Annual Report and took a number of actions in their region to promote access, improve service linkages and increase knowledge of maternal mental health service availability in the maternity sector. Actions included enabling LMCs and general practice to use a single point of entry to the maternal mental health pathway using an electronic referral system. This single point of entry system is titled the Coordinated Access Response Electronic System (CARES).

Across the DHB, general practice already uses CARES; and now LMCs can use the same system to refer women directly to the primary mental health services provided by PHOs in the area.

Movement to an electronic referral system will be developed once LMCs have IT access that facilitates the secure transfer of confidential client information. CARES will also triage new referrals to ensure timely and appropriate access to services.

To improve service linkages, primary mental health care representatives provide up-to-date information on mental health services in the region at local maternity access holders meetings. The DHB also plans to update or develop their local referral pathways to primary, secondary and tertiary mental health services over the next year.

Nelson Marlborough DHB has also implemented other initiatives to increase mental health service knowledge within the maternity sector including the development of brochures, and quarterly visits from the Regional Maternal Mental Health service in Christchurch to provide information to maternity service providers.

West Coast DHB

West Coast DHB has a designated role to coordinate maternal mental health services between primary and secondary care providers in their region. This is the Mothers and Babies Resource/Liaison Nurse working within West Coast DHB mental health services. The purpose of this role is to ensure care is coordinated in a manner that is both responsive and proactive. It includes the provision of:

- Support and advice to both the woman and the wider team members of mental health issues and concerns;
- Assessment and screening services for developing mental health issues;
- Direct care and oversight of women with existing mental illness during pregnancy, in collaboration with the midwifery team;
- Access to psychiatrist review during pregnancy if needed, and
- Access to specialist maternal mental health services.

The DHB also has a clearly defined referral pathway to access maternal mental health services, although often referrals are less formal and are based upon existing relationships between primary and secondary care services.

Northland DHB

Northland DHB has a person employed as Maternal Mental Health Coordinator. That person is responsible for assessment, education and liaising for maternal mental health services. They can also assess women at home or in the hospital.

This role involves liaising with primary and secondary mental health and maternity care. Women can be referred through this pathway up to 12 months post-partum. The Maternal Mental Health Coordinator has also been closely involved in the development of the new perinatal infant mental health service.

Maternity Ultrasounds

Our focus

To investigate national variability in equity of access to primary referred maternity ultrasounds, including cost, timing and quality. Ultrasound scans are a core part of antenatal services. The 2013/14 DHB Service Coverage Schedule states that:

“DHBs will ensure that all women have access to specialist services at no charge including ... radiology services (including primary referred ultrasound services).”

However, we note that many DHBs do not have the capacity to do this. As a result, ultrasounds are often made available through private providers at a cost to the woman in the form of a co-payment.

Current evidence suggests that a woman who has no complications of pregnancy, is low risk, engages with health services in the first trimester of pregnancy, and carries her baby to term would be expected to be referred for two ultrasound scans.^{9,10} The first scan is for screening and dating purposes in early pregnancy. Typically, this scan occurs between 10 to 12 weeks of pregnancy. The second scan routinely offered to women is a fetal anatomy scan between 18 and 20 weeks' gestation.

We focused on primary maternity ultrasounds. Provision of primary ultrasounds for the two occasions noted above, plus at other times in pregnancy, are publicly funded under the Section 88 Primary Maternity Services Notice 2007 (Section 88 Notice).

Primary maternity ultrasounds do not include ultrasounds performed when a woman is under the care of secondary or tertiary maternity services. The vast majority of primary maternity ultrasound services in New Zealand are carried out by private radiology providers. The number of claims for ultrasounds made per woman under Section 88 Notice is not capped. Many ultrasounds provided by private radiology providers also require the woman to make a co-payment. This method of funding potentially influences demand, access by women, equity of access and quality of ultrasounds.

The NMMG wanted to gain a clearer understanding of how ultrasounds are provided in each DHB area, particularly those provided by private radiology services, the arrangements that are in place within DHBs, whether secondary ultrasound referrals also occur under this model, and the impact this has in terms of access for women, service quality and funding efficiency.

What we've done this year

We assessed information provided by the Ministry regarding primary maternity ultrasounds in New Zealand. This information was sourced from the Section 88 Claims, and is arranged by the financial year of due date or actual date of birth. This captures all scans for a pregnancy even when they are distributed across two financial years.

We communicated some of this information to a number of professional colleges including the Royal New Zealand College of Radiology, the Royal New Zealand College of Obstetricians and Gynaecologists, and the New Zealand College of Midwives. We asked for their feedback on the trends and for further information to help us understand this topic.



⁹ National Collaborating Centre for Women's and Children's Health. 2008. Guidelines for antenatal care: routine care for the healthy pregnant woman. London: National Institute for Health and Clinical Excellence.

¹⁰ Whitworth, M., Bricker, L., Neilson, J.P. & Dowswell, T. 2010. Ultrasound for fetal assessment in early pregnancy. Cochrane Database Systematic Review, 14(4):CD007058. doi: 10.1002/14651858.CD007058.pub2.

We also provided this information to DHBs. We asked the DHBs for:

- Feedback on the reasons for trends seen over time in the numbers of primary maternity ultrasounds performed;
- Their views on the information that providers give to consumers about primary maternity ultrasounds;
- Any information DHBs have on how many primary maternity ultrasound scans are performed per pregnancy within their hospitals (paid for by their DHB's bulk funding), and
- What the indications are for these scans.

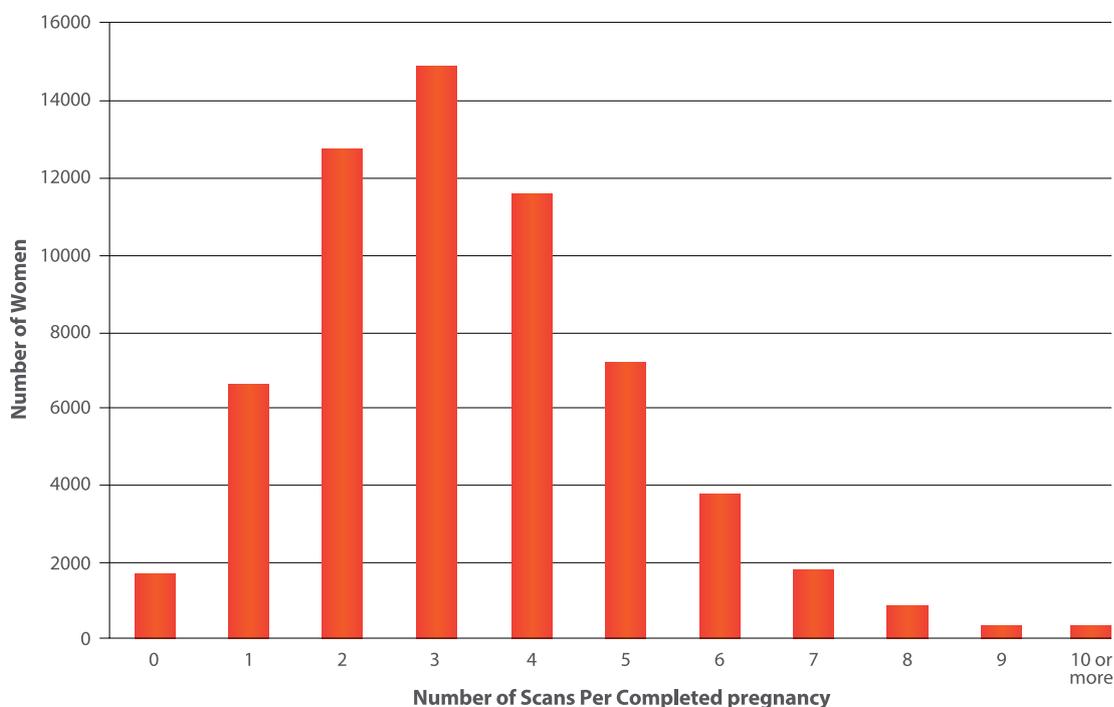
We liaised with the National Screening Unit to inform our work and avoid duplication in relation to first trimester screening for chromosomal abnormalities, which occurs between 10 and 12 weeks' gestation. We also asked the Medical Radiation Technologists Board for information regarding training and competency of maternity sonographers.

What we found

Ultrasound data

In 2011/12 the average number of primary maternity scans claimed under the Section 88 Notice for women who had a live birth or stillbirth was 3.4. The most common number of scans received was three.

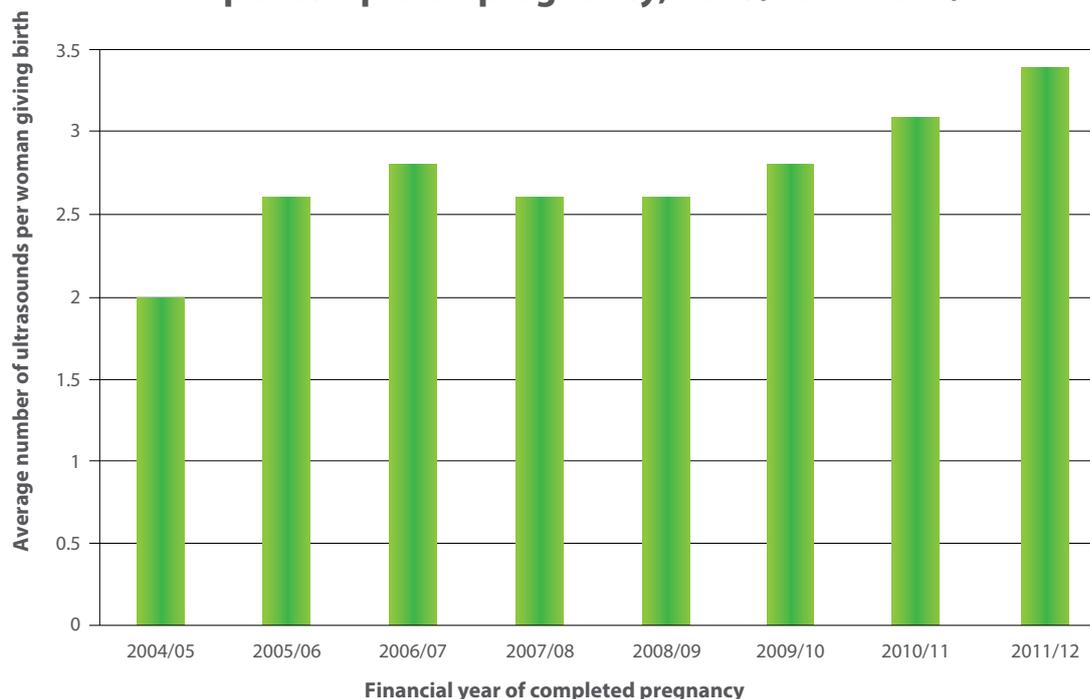
Number of primary maternity ultrasound scans per completed pregnancy, 2011/2012



Source: Section 88 Claims, Ministry of Health

Furthermore, the average number of primary maternity ultrasounds per woman who has a live birth or stillbirth has increased over time, from 2.6 per birth in 2005/06 to 3.4 per birth in 2011/12.

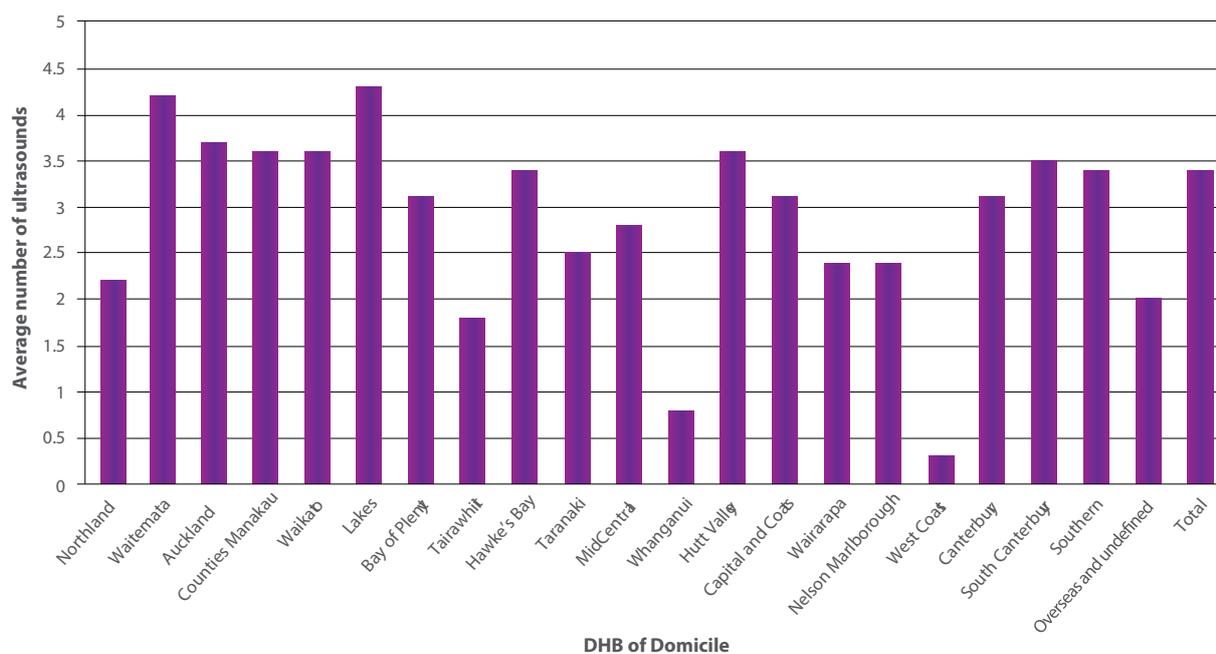
Average number of primary maternity ultrasound scans per completed pregnancy, 2005/06 to 2011/12



Source: Section 88 Claims, Ministry of Health

There is some regional variation amongst DHBs in the average number of primary maternity ultrasounds per woman experiencing a live birth or stillbirth. However, some DHBs have very low average ultrasounds claimed per birth, likely indicating that the DHB in these regions is a major provider of primary maternity ultrasounds.

Average number of primary maternity ultrasound scans per pregnant woman by DHB of domicile, per completed pregnancy 2011/12



Source: Section 88 Claims, Ministry of Health

Data not presented here suggests that the majority of primary maternity ultrasounds (80%) are being performed for either screening for Down syndrome and other conditions, checking fetal anatomy, dating, threatened miscarriage and for concerns about fetal growth in the third trimester.

In-depth feedback from care providers

Complexity of care

A number of stakeholders noted that the complexity of care of pregnant women is increasing. This includes increases in average BMI, older maternal age, more assisted reproductive technology and more mothers with co-morbidities. They noted that women with high BMIs are more difficult to palpate making assessment of fetal growth through abdominal palpation difficult, and as such, ultrasound a more useful tool.

Normalisation of extra scans

Midwives reported increasing pressure from women to have a scan, or a repeat scan, if the baby's face or gender has not been seen. There is also pressure to have a further scan at later gestations to ensure that the baby is healthy. The scan makes the baby more accessible and real for the woman and her partner.

Increasing awareness of the need for detecting small-for-gestational-age (SGA) babies

Stakeholders also commented that increasing awareness of risks to SGA babies is contributing to the rise in scan numbers. Although Gestational Related Optimal Weight (GROW) charts are being used for the antenatal detection of SGA babies, ultrasounds are also used to confirm optimal growth. Some DHBs and midwives believe that this is resulting in significantly more non-SGA babies being scanned. Moreover, once a baby is scanned it is likely to get repeat growth scans to monitor ongoing growth, even if the first did not show SGA.

Scans being used for dating

A first scan should be carried out at 10-12 weeks as a nuchal translucency scan and dating scan. There should be no need for an earlier dating scan "just to ensure the timing is right" for the screening scan, yet feedback to the NMMG indicated that such a scan at six weeks was occurring consistently in some areas.

Request for repeat scans

Some feedback noted that there seemed to be an increase in requests for repeat scans. From radiologists the reasons for this were varied, but it was noted that it may be related to inadequate time for scans to be completed properly.

Education of women

Some stakeholders noted inadequate preparation by the woman resulted in women needing to be rebooked for a scan.

DHBs were asked about the maternity ultrasound information given to women by providers. Mostly they noted that pamphlets, such as those produced by the Maternity Services Consumer Council, the National Screening Unit and local private radiology providers, are distributed when a scan is booked by an LMC. In a small number of DHBs, websites are also used to provide information.

Most DHBs do not provide primary maternity ultrasounds

Most DHBs reported they do not provide any primary maternity ultrasound scans; these are provided in the community and claimed for under the Section 88 Notice with all providers charging the woman a co-payment fee. Essentially, the NMMG uncovered large variation, inequity in relation to co-payments, and potential for women to refuse to attend a scan due to access issues and an inability to pay.

The training and competency of obstetric sonographers

We wanted to see whether there were standards regarding obstetric ultrasound quality in New Zealand, as this issue was raised in our correspondence with various stakeholders. The Medical Radiation Technologists Board ("the Board") provided us with information about the training and on-going professional competency standards that obstetric sonographers are required to meet.

The changes we expect to see next

During our investigations into primary maternity ultrasounds this year, we have found a number of interrelated factors that may be contributing to rising ultrasound rates in New Zealand. This work stream has raised more questions for the NMMG than it has provided answers. There is much work to be done and, in light of this, we expect the following to occur:

1. We ask the Ministry to conduct a quality audit and investigation into the rising numbers of ultrasound scans being claimed for against the Section 88 Maternity Notice;
2. We intend to co-opt a College of Radiology member onto the NMMG for the next year to provide specialist advice as part of the NMMG whilst we uncover the rationale behind increasing ultrasound numbers;
3. We invite the Ministry to consider the best way to fund ultrasound scans so that there is no charge for women, and no incentive to request more scans;
4. DHB should work with consumer networks through the MQSP to ensure they're fully informed about the reason for ultrasounds and their screening purpose;
5. DHBs and the professional colleges to prioritise ultrasounds by jointly reviewing the evidence in relation to scans and the indications for ordering them in relation to the evidence, and
6. Relevant professional colleges to look at this information and provide clinical leadership by discussing the following with their members:
 - Whether professional standards are being followed in relation to requests for scans, and
 - The factors driving the increase in ultrasounds and whether these are based on evidence.

Good example of investing in ultrasounds

Northland DHB, Auckland DHB, Counties Manukau DHB and Waitemata DHB

The Northern Region Radiology Network has recently formed a group to focus specifically on obstetric ultrasound quality assurance. The initiative which includes representation from the four Northern DHBs (Northland, Auckland, Counties Manukau and Waitemata) has arisen as a direct result of the concerns raised earlier in the year by the NMMG.

The group also includes representatives from private ultrasound providers in the region as well as obstetric and fetal medicine specialists and a midwife.

Although the group is currently still in its' initial planning and establishment phase, it has already received support from many of the stakeholders involved.

As part of their focus on quality ultrasound services, the group will be connecting with maternity groups in order to share ideas and information regarding the issues seen within this area.

Connecting and Supporting Maternity Consumer Members of the Maternity Quality and Safety Programs

Our focus

To investigate the issue of consumer membership to ensure consumer perspectives are integral to the development of DHB Maternity Quality and Safety Programmes (MQSPs). In our last annual report it was noted that a number of DHB MQSPs had not engaged with, or utilized, consumer representatives well over the previous year.

Consumers need to be involved in discussions and decision-making at every level of the maternity sector. Consumer members should be able to gather information and support from their communities and from organisations aligned to the maternity sector to be most effective. We want to ensure that MQSP consumer members are properly involved in MQSP decision-making and are aware of the wider context of consumer involvement in health care.

MQSP governance group should engage consumer members to help determine the work streams within the DHB's Maternity Quality and Safety Programme. Work done under the MQSP will then reflect the consumer members' priorities for that community.

What we've done this year

The NMMG's consumer member, Rose Swindells, got in touch with MQSP coordinators and consumer members in many DHBs. She asked them about the consumer representation on their MQSP, other ways they involve consumers and how they support consumer members of the MQSP. She asked consumers whether they feel involved and listened to within the MQSP discussions.

We also asked the Ministry to host a DHB MQSP consumer representative forum, which will be held in August 2014. The aim of this being for consumer members of the MQSP in DHBs to share experiences and different ways of working as consumer members, and build linkages with consumer organisations with an interest in maternity, in order to support consumer members in their local MQSP roles. We are invited to attend this consumer forum.



What we found

Engaging consumers

We found that most DHBs engage consumers in their MQSP by having a consumer member on the governance and operational groups rather than other forms of consumer involvement such as surveys, consumer groups, or links to community groups.

In general, most DHBs had one consumer member, except one DHB, which has opted to hold dual consumer and provider meetings. Mostly, consumers were either 'shoulder-tapped' by MQSP members or were recruited via an Expression of Interest put out by the DHB. In some cases consumers were aligned to community maternity groups.

Some DHBs have tried to invite consumers from specific populations, such as Māori, Pasifika, young mothers or rural communities, to ensure that the MQSP consumers are more representative of the DHB population.

The role of consumers

The consumers who spoke about their role at DHB meetings were still, in the main, struggling and some felt overwhelmed. They believed this was because they have had limited guidance on their role and because they were isolated in their role. The NMMG notes there has been high turnover of consumer members within the MQSP.

Some consumers also felt as though they were expected to represent the views of all consumers. They were unsure when and how they were expected to engage with other consumers in the community and how they might bring up issues in meetings, even if they have received feedback from their community.

Most of the consumers acknowledged that there is no clear process for feeding back to the community or even to the women they have spoken with individually. The work at this level is often strategic and it makes it hard to align specific feedback given to consumer members. This was particularly difficult when the outcomes of the MQSP group meetings were not always clear.

Many consumer members are uncertain about their on-going role due to the "business as usual" wording used by the Ministry when discussing the MQSP. Whilst we understand that the Ministry is referring to fact that MQSP will now become a core component of daily DHB practice, consumer members interpreted this as DHBs will be returning to their "business as usual" model, thereby removing MQSP (and MQSP funding) from their priorities list.

Support provided to help consumer members

All consumer members that we talked to were paid in some form, mostly on an hourly rate, for meetings. It was unclear whether consumers were reimbursed for preparation time outside of meetings. One member is employed as a staff member by the DHB for a small number of hours per week. This representative reported having more time to be able to engage with different consumers to reflect the DHB population. All the consumer members we spoke to are keen to collaborate and work hard to improve maternity services in their area. Giving them clarity around their roles and supporting them to contribute fully will ensure this process has integrity.

The changes we expect to see next

1. All DHBs must be clear that the role of consumer representatives on maternity groups is not to represent the individual views of every consumer. Instead, it is to provide a consumer perspective and to link with other consumers or organisations representing consumers in the region. As such, we recommend that the Ministry reconsider the title of the consumers and refer to them as consumer members of MQSP rather than consumer representatives.
2. Consumer members must be reimbursed in some way for their time.
3. DHBs must support consumer members by facilitating different ways for them to link in with women in the community and give them the means to feed back information to the MQSP.
4. The Ministry needs to reassure consumer members that MQSP remains a core component of DHB practice.
5. We also expect the Ministry to hold a second consumer member forum in 2015 to ensure that consumer members can build on this year's forum with a further chance to meet and provide support to each other nationally.
6. We would also like to see the development of networking tools such as a facebook page so that consumer members can build their networks and have a platform to share concerns or raise issues that are occurring within their DHBs.

Good example of promoting consumer engagement

Waitemata DHB

Waitemata DHB provided information on their consumer representatives as part of their draft MQSP annual report. The DHB's MQSP clinical governance group has two consumer representatives. They have been part of these meetings since mid-2013.

The consumer representatives are supported by the MQSP coordinator. The coordinator provides training, as well as regular contact and meetings to support them in their role. They receive remuneration for attendance at meetings which includes time for reading required information. Remuneration is given in accordance with the Waitemata DHB non-employee schedule.

Both consumer representatives provide feedback to the clinical governance group. They are also actively involved in planning and providing oversight to the consumer feedback process. In the Waitemata MQSP draft annual report, there was also a small section written by these two consumer representatives.

Both representatives feel acknowledged and respected at the monthly meetings. They pointed out that other members of the clinical governance group make a particular effort to explain and engage them during meetings. They believe that their greatest impact has been on representing consumers with regard to proposed research, and in developing the idea of electronic feedback stations for consumers within services.

The DHB's MQSP draft annual report states that they are also currently considering how best to communicate regularly with consumers of Waitemata DHB services in a broader sense.

The New Zealand Maternity Clinical Indicators

Our focus

To review and contribute advice on the New Zealand Maternity Clinical Indicators to the Ministry.

The Clinical Indicators are a set of clinically relevant issues, which can be measured using available data collections. They are a key part of the national MQSP as they allow clinical data to be benchmarked at the national level using standardised definitions. The Clinical Indicators were chosen by an expert working group established by the Ministry and indicators build on previous work undertaken across Australasia. Reports discussing the Clinical Indicators have now been released containing data from 2009, 2010 and 2011.^{11,12,13}

Last year, the NMMG reviewed the 2011 Clinical Indicators as a part of ensuring that Standard One of the National Maternity Standards is met, in that maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies. We also supported revisions to the Clinical Indicators to support the 2012 report.

Due to the timing of the development of the next Clinical Indicators report, we were not able to review the 2012 Clinical Indicators prior to the publication of this report. Instead, we focused on the clinical coding that affects the data collated in the Clinical Indicators reports. The aim of this was to ensure that the quality of data collected is nationally consistent. This issue is also particularly important to ensuring that Standard One is met.

What we've done this year

We liaised with the Ministry regarding the information used in the 2012 Clinical Indicators and the recommendations we made in the NMMG's 2013 Annual Report. We were keen for the Ministry to consult with the original expert working group responsible for developing the Maternity Clinical Indicators. Unfortunately, this process meant that the 2012 Clinical Indicators were not published prior to the publication of the NMMG's 2014 Annual Report.

Due to this delay, we focused instead on the national consistency of maternity clinical coding. This coding can affect the data reviewed in the Maternity Clinical Indicators reports. In feedback to the NMMG, some DHBs expressed concern that their data did not match the data collected by the Ministry and subsequently reviewed by the NMMG. We asked MQSP coordinators for their thoughts on clinical coding in their regions.



¹¹Ministry of Health. 2012. New Zealand Maternity Clinical Indicators 2010. Wellington: Ministry of Health.

¹²Ministry of Health. 2012. New Zealand Maternity Clinical Indicators 2009. Wellington: Ministry of Health.

¹³Ministry of Health. 2013. New Zealand Maternity Clinical Indicators 2011. Wellington: Ministry of Health.

In 2013 we recommended...

In our 2013 Annual Report, we suggested that the Ministry introduced to the current Maternity Clinical Indicators a number of new or revised indicators:

Additions to the indicator set

1. Timing of first registration with LMC or DHB maternity services (to reflect the NMMG's work stream on this issue);
2. Maternal tobacco use (to support the work of the maternity indicator in the Better Help for Smokers to Quit target);
3. Maternal Intensive Care Unit (ICU) and High Dependency Unit (HDU) admissions;
4. Term babies (without congenital abnormality) transferred to Neonatal Intensive Care Units/Special Care Baby Units;
5. Eclampsia;
6. Small for gestational age (less than 10th percentile), and
7. Vaginal Births After Caesarean (VBAC).

Modifications to the definition of standard primiparae in the Maternity Clinical Indicators

1. Parity - include data on parity status from the registration claims submitted by LMCs under the Primary Maternity Services Notice (Section 88 Notice). Where parity status is not available from registration claims, use the previous method of estimating parity, and
2. Gestation - match records of the mother to those of the baby or babies, and use gestation at birth (weeks) where available.

We also suggested that the Maternity Clinical Indicators data should be sourced from the National Maternity Collection for future reports to increase the scope and completeness of the data available.

We expected that the Ministry would consult with other maternity stakeholders before making any changes to the current New Zealand Maternity Clinical Indicators. This might include those who were initially involved in the development of the Maternity Clinical Indicators, the PMMRC and the respective health professional colleges.

We also asked all DHBs to comment on their Maternity Clinical Indicators data in their next MQSP annual reports and give reasons for any variability. Any DHBs that were outliers in the data were to expect questions from the NMMG, including questions on the DHB's plans to understand why this had occurred and how they expected to address it.

What we found

The Ministry agreed to make the changes we recommended, which were supported by the Clinical Indicators Expert Working Group. The next Clinical Indicators report is in development.

In terms of DHB clinical coding, we found that there is significant variation in the quality of maternity coding within, and between, DHBs. Some DHBs have only one person doing all the maternity coding (which helps with consistency), whilst others consider it a general item. At present there are no national training programmes available for maternity coders.

The changes we expect to see next

1. Ministry have been advised of our concerns and asked to meet with representatives of NMMG in relation to looking at coding of data concerns
2. DHBs need to provide more support for clinical maternity coders, including appropriate documentation regarding guidelines for maternity coding, in order to improve their data quality.
3. Communication between the coders and maternity clinicians in each DHB also needs attention. Therefore, we recommend that the Ministry runs maternity coding workshops with coders and maternity clinical leaders in each DHB. We expect these to be facilitated by a maternity clinical coding expert to ensure national consistency.
4. The expert working group has met and responded to the NMMG suggestions and we have, in the main, accepted their advice. The next publication of the indicators should now be released.

Ministry of Health

Report on Maternity

Our focus

To review the Ministry of Health Report on Maternity and give advice for future reports. We continue to focus on this work stream as it is a key source of data for monitoring the standard of maternity services across New Zealand, and it is part of the NMMG's Terms of Reference.

The Ministry's Report on Maternity presents health statistics on the pregnancy and childbirth of women who gave birth in New Zealand (to live-born or stillborn babies). The report uses data collected in the National Maternity Collection, hospital discharge data from the National Minimum Dataset, and information on primary community events from LMC claim forms. This report is statistical in nature and designed to inform debate.



What we've done this year

We liaised with the Ministry to obtain an update on when their next Report on Maternity would be published.

In 2013 we recommended...

In our 2013 Annual Report, we recommended that:

1. We want to see the Ministry continue to produce an Annual Report on Maternity, and for its contents to be strengthened by:
 - Reporting preterm births as a percentage of total deliveries, and
 - Investigating other ways of classifying ethnicity - we noted that the category 'Other' included a number of diverse ethnic groups. We recognise that this is a commonly used way of classifying ethnicity, but we want the Ministry to explore different classification methods.
2. Each DHB must review its data and provide comment on the outcomes for women and their babies, and advise the work they have done as a result of this information in next year's MQSP Annual Reports.

What we found

The next report will be published after the New Zealand Maternity Clinical Indicators 2012 are published. It will be a full report for the 2012 period, and will be available in early 2015.

The NMMG look forward to reviewing this Report on Maternity as part of next year's work plan.

The changes we expect to see next

1. We expect to see the changes we recommended in 2013 incorporated in the Ministry's next Report on Maternity.

District Health Board Maternity Quality and Safety Programme Annual Reports

Our focus

To review the Maternity Quality and Safety Programme annual reports produced by each DHB. Overview of the MQSP is one of the main activities of the NMMG in our role of ensuring the New Zealand Maternity Standards are met. We believe it is particularly important to give feedback to DHBs and support to those who are not delivering the MQSP at an acceptable level.

Last year we made a number of recommendations on the DHB 2012/13 MQSP annual reports. This year we reviewed 2013/14 MQSP annual reports to ensure that DHBs considered our recommendations from 2013 and have achieved the goals they set out in their previous annual reports. We have also increased our monitoring role on the MQSP this year given that the MQSP is moving out of the implementation phase and into the continuous quality improvement phase.

As part of this work stream we are continuing to monitor implementation of the '2012 Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)', a previous focus of the NMMG. We particularly wanted to review whether DHBs have used clinical leadership to introduce policies related to emergency transport and retrieval.

What we've done this year

We reviewed each DHB's 2013/14 MQSP draft annual reports against criteria such as whether the DHB:

- Achieved the goals set out in its previous MQSP annual report;
- Considered and acted on the recommendations contained in the NMMG's 2013 annual report;
- Discussed the '2012 Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)', including whether they have used clinical leadership to introduce policies related to emergency transport and retrieval;
- Discussed the topics and information raised in letters from the NMMG;
- Included any discussion of national priorities, and
- Aligned future priorities with those identified by the NMMG.

Specific feedback on each DHB's draft annual report was provided to the Ministry. This was also provided to each DHB (via Ministry feedback) in order to inform the final annual reports. The template used for the review of the Draft Annual Reports by the NMMG was also provided to the DHBs so that they can be used when drafting future annual reports.

We also liaised with the Ministry to better understand how the MQSP aligns with wider quality improvement work in each DHB.

What we found

We found that much of the wider quality improvement work occurring in DHBs is guided by the Health Quality and Safety Commission (HQSC). DHBs are informed on Ministry expectations as part of DHBs' annual planning processes, and these expectations are discussed in DHB quality accounts. These expectations do not specifically mention the MQSP or maternity. In order for the MQSP to progress post June 2015 it is important that this work in maternity is aligned and incorporated as a distinct workstream within the DHB quality accounts.

In 2013 we recommended...

1. All DHBs should focus on national maternity priorities in their next MQSP. However, we do understand that there will be local variations on the work each DHB carries out in relation to improving maternity quality and safety.
2. DHBs must improve engagement with maternity consumers in the coming year.
3. We expect that all DHBs will:

Manage the MQSP process

- Hire a permanent MQSP coordinator;
- Be able to demonstrate how they are working towards achieving the goals set out in their MQSP strategic plans;
- Make more progress in 2013/14 given that this is the second year of the programme;
- Make goals more specific - they need to be measurable so they can be reported upon;
- Work more closely with wider DHB quality improvement teams;
- Reflect national priorities in future work, and
- Consider the NMMG's priorities when outlining future activity.

Improve engagement with consumers

- Have at least one, if not more, consumer members on clinical governance groups and supply training to help them contribute effectively;
- Incorporate other ways to get consumer feedback into reporting systems, and
- Ensure that MQSP publications are accessible to consumers, and that they are relevant and easy to read.

What has changed since then?

We were pleased that there was an overall improvement in the quality of the 2013/14 annual reports in comparison to 2012/13. However, there were still areas that required attention. These included:

- Consumer members - there were concerns that in some DHBs consumer members did not have a clearly defined role and were not networked with other local consumer groups aligned with maternity. In one or two DHBs there were still no consumer members on the MQSP at any level including governance, or they had resigned and had not been replaced;
- No mention of previous goals - the NMMG would like an update on the outcome of the previous years' goals;
- Future priorities were not mentioned, nor were the NMMG's priorities, in some reports, and
- Clinical leadership was unclear in a number of the reports.

We also noted in the MQSP draft reports that there seemed to be little alignment of maternity within the wider quality improvement work in their DHBs. If there is not some mutuality between the two areas of quality work in DHBs it may prove difficult to maintain the quality agenda in maternity, as it will not always be well understood by the wider organisation.

This feedback was provided to DHBs by the Ministry of Health.

We accept that these were draft reports and that the final documents may be substantially different.

The changes we expect to see next

1. We expect the DHBs to incorporate feedback from the NMMG and the Ministry into their final 2013/14 MQSP annual reports.
2. Once the DHB MQSP annual reports are finalised and published, they must be made publicly available on each DHB's website.
3. The MQSP must be seen as business as usual for DHBs and should be aligned with, and supported by, the DHB quality framework.
4. We expect that DHBs will align their MQSP with their wider quality agenda, in order to support an integrated quality improvement approach. We want DHB Quality teams to have an understanding of the MQSP and link this to other relevant quality work in their region – it should not be kept separate. This is vital if the MQSP is to ever become a part of the wider quality work of DHBs.
5. In order to support DHBs to do this, we would like the Ministry (and the HQSC) to ask DHBs to discuss the MQSP as part of their wider quality work, including as part of the quality accounts.

Update on Previous NMMG Work

In our 2013 Annual Report, the NMMG made a number of recommendations for improvements within the maternity system across nine work streams. Not all of these work streams continued in 2014. This section outlines any progress made in relation to 2013 recommendations.

2013 work streams

The 2012 Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)

In 2013 we recommended that:

1. DHBs should be using MQSP governance groups to monitor the implementation of the Referral Guidelines;
2. The Referral Guidelines should be communicated effectively to maternity consumers, making processes more transparent;
3. Updates to referral policies need to be completed in conjunction with St John and other ambulance services, and
4. We want to see that DHBs are engaging with ambulance services to improve the emergency transport of women in labour.

This year we noted a number of developments:

- Almost all DHBs had discussed the implementation of the Referral Guidelines in the MQSP annual reports. Many had entire sections on this topic where they discussed work carried out to support implementation and planned future work, including audits. Some had also considered the recommendations of the NMMG in 2013, such as updating emergency transport processes, and
- We were pleased to see that many of our recommendations had been acted upon. However, we did note that some DHBs were struggling with the clinical leadership required for implementing the Referral Guidelines.

Next year we expect to see more changes:

1. We want to see all DHBs clearly discuss the clinical leadership and integration required to achieve the implementation of the Referral Guidelines in their area, and
2. The NMMG will continue to monitor this topic in upcoming MQSP annual reports as part of a wider focus on national guidelines.

Smoking amongst pregnant women

In our 2013 Annual Report we recommended the following:

1. The Ministry should expand the maternity indicator of the 'Better help for smokers to quit' target to include data from primary care providers (GPs and others). The sharing of information will help the integration of services, particularly between LMCs and GPs, and enable more effective monitoring of the success of intervention;
2. Every DHB will work with all aspects of maternity services in its area and meet the Ministry's target of "Progress towards 90 percent of pregnant women who identify as smokers at the



time of confirmation of pregnancy in general practice or booking with an LMC are offered advice and support to quit”;

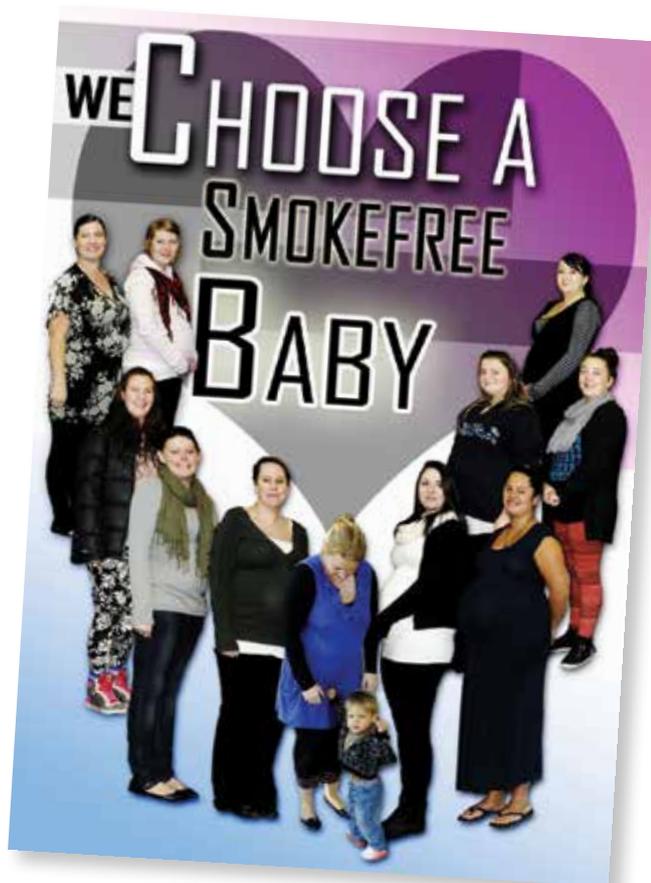
3. DHBs must discuss this target with LMCs and general practice in any clinical governance groups that have been established as part of their DHB’s MQSP, and
4. We expect each DHB to comment on this in its next MQSP annual report.

This year we were pleased to see a major development:

- In 2014 we were notified by the Ministry’s Tobacco Control Team that there will soon be capacity to expand the monitoring of the ‘Better help for smokers to quit’ maternity indicator to include primary care data. This was made possible by a new tool developed in conjunction with MedTech, which will be used to create a separate record for pregnant mothers and collate data on smoking cessation advice when women are seen in pregnancy by their GP. We were very pleased to hear that our recommendation from last year had been taken forward by the Ministry. As we noted in 2013, the sharing of information will help the integration of services, particularly between LMCs and GPs, and provide more effective monitoring of the success of intervention.
- We were also pleased to see that DHBs commented on this target in their MQSP annual reports.

Next year we expect to see more changes:

1. We recommend that the Ministry considers requiring PHOs to use the new tool for recording the smoking cessation (ABC) advice given to pregnant women in their general practices. Reporting on this to the Ministry could form part of the PHO contractual reporting requirements or as part of their quality framework.



The NMMG

Going Forward

In 2013/14, the key areas of focus for the NMMG were:

1. Timing of registration with an LMC including the quality of the first assessment by whichever practitioner the woman sees ;
2. Variation in gestation at birth;
3. National consistency in the provision of coordinated maternal mental health services;
4. National variability in access to, and quality, of primary maternity ultrasounds;
5. Connecting and supporting maternity consumer representatives;
6. The New Zealand Maternity Clinical Indicators;
7. The Ministry of Health Annual Report on Maternity, and
8. DHB MQSP annual reports.

We plan to continue our focus on these issues as well as maintaining a focus on Referral guidelines and smoking targets as we have done this year. Other potential areas of interest for the NMMG include:

- Rural maternity units and the accessibility of maternity services in these areas;
- National Maternity Clinical Guidelines, and
- Clinical Coding.

We are also interested in framing our next year's work plan within the New Zealand Triple Aim for Quality Improvement, which is used by other groups including the Health Quality and Safety Commission¹⁴.

The three aims of this are:

- Improved quality, safety and experience of care;
- Improved health and equity for all populations, and
- Best value for public health system resources.

The work streams and work programme of the NMMG for 2014/15 will be finalised in August 2014.



¹⁴ <http://www.hqsc.govt.nz/about-the-commission/>

Acknowledgements

We have seen tremendous energy in the maternity sector over the last 12 months. The NMMG would like to thank the following groups and individuals for their contribution to our work this year:

- The consumers who engaged so openly both with the NMMG and DHBs, so that we could all better understand the perspectives of pregnant women;
- The professionals within the maternity sector who worked so hard to provide us with detailed information;
- Staff at the Ministry of Health for their openness and transparency when dealing with all the members and secretariat of the NMMG;
- The Minister of Health and the Acting Director-General of Health for ongoing commitment both to the NMMG and the maternity sector;
- All involved in the delivery of the DHB Maternity Quality and Safety Programmes - seeing collaboration between professionals and consumers has been particularly encouraging, and
- Chief Executive Officers and other members of the DHBs throughout New Zealand who have taken responsibility for providing such timely and robust responses to questions from the NMMG. We could not do this important work without your support.

We look forward to working with you all again as our work continues into 2014/15.

Appendix One: Terms of Reference for the National Maternity Monitoring Group, 2013-2016

Introduction

1. This document sets out the:
 - a) roles and responsibilities of the National Maternity Monitoring Group;
 - b) work programme and reporting requirements;
 - c) composition of the National Maternity Monitoring Group, and
 - d) terms and conditions of appointment.

Background

2. The New Zealand Maternity Standards (Ministry of Health 2011) consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services:
 - a) Standard 1: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies;
 - b) Standard 2: Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage, and
 - c) Standard 3: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.
3. These high-level statements are accompanied by specific audit criteria and measurements of these criteria. One of the criteria is that a National Monitoring Group be established to oversee the maternity system and the implementation of the Standards.

Role of the National Maternity Monitoring Group

4. The role of the National Maternity Monitoring Group is to oversee the New Zealand maternity system and to provide strategic advice to the Ministry of Health on priorities for improvement.
5. Standard 1 of the New Zealand Maternity Standards states “a National Monitoring Group, consisting of a small number of clinical sector experts and consumer representatives ... provides oversight and review of national maternity standards, analysis and reporting. The National Monitoring Group provides advice to the Ministry on priorities for national improvement based on the national maternity report, nationally standardised benchmarked data, the audited reports

from DHB service specifications, Maternity Referral Guidelines, and the Primary Maternity Services Notice 2007”.

6. Standard 1 sets out audit criteria, applicable at the national level, to which the Ministry of Health and the professional colleges are accountable to. These additionally inform the role of the National Maternity Monitoring Group.
7. The National Maternity Monitoring Group is not a decision-making body. While it may provide recommendations to the Ministry of Health, responsibility for decision-making and implementation rests with the Ministry of Health and/or other relevant participants in the maternity system.

Responsibilities and reporting requirements of the National Maternity Monitoring Group

8. The National Maternity Monitoring Group will meet at least four times per annum, and will undertake other communication as necessary to deliver the agreed work programme.
9. The National Maternity Monitoring Group is responsible for identifying priorities for action or investigation, and agreeing a 12-month work programme with the Ministry of Health at the beginning of each year of operation.
10. The work programme may include but is not limited to:
 - a) Providing expert advice on data released through the New Zealand Maternity Clinical Indicators, national maternity consumer surveys and the New Zealand Maternity Report, which are published from time to time by the Ministry of Health.
 - b) Contributing to the review of the New Zealand Maternity Clinical Indicators at a minimum of three-year intervals and providing advice on the modification, addition or withdrawal of any indicators.
 - c) Identifying priorities for national clinical guidelines / guidance for maternity including recommendations on best clinical practice, and providing advice on how these should be developed and implemented.
 - d) Reviewing reports of the Perinatal and Maternal Mortality Review Committee (PMMRC), identifying the implications for the maternity system of the findings of the PMMRC and providing advice on system response to these findings.
 - e) Reviewing and assessing the annual reports

produced by each DHB as part of its Maternity Quality and Safety Programme.

f) Reviewing and assessing other maternity reports produced or commissioned by the Ministry of Health, DHBs, professional colleges, consumer groups or other stakeholders as requested from time to time.

11. The National Maternity Monitoring Group may be asked to provide advice on any other matters related to the quality and safety of maternity care and services by the Ministry of Health from time to time.
12. The National Maternity Monitoring Group will produce an Annual Report by a date negotiated with the Ministry of Health detailing:
 - a) Work carried out, conclusions reached and recommendations made during the previous year.
 - b) Its priorities and work programme for the following year.

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

13. The Perinatal and Maternal Mortality Review Committee (PMMRC) is a Mortality Review Committee, appointed under section 59E of the New Zealand Public Health and Disability Act 2000 by the Health Quality and Safety Commission.
14. The PMMRC considers maternal and perinatal mortality, and other morbidity as directed by the Minister in writing. It prepares an Annual Report, which includes its advice and recommendations.
15. In providing its advice, the National Maternity Monitoring Group will take account of the findings on maternal and perinatal mortality and morbidity by the PMMRC set out in its Annual Report.
16. Where the PMMRC recommends specific action by maternity system stakeholders, the National Maternity Monitoring Group will advise the Ministry on an appropriate response to these recommendations.
17. The National Maternity Monitoring Group will meet at least once annually with the PMMRC.

Composition of the National Maternity Monitoring Group

18. The National Maternity Monitoring Group will have a maximum of eight members, not including ex-officio members from the Health Quality and Safety Commission and Ministry of Health.
19. Composition of the National Maternity Monitoring Group will balance requirements for:
 - a) Expertise necessary to analyse different sources of information on the maternity system and make recommendations based on this analysis.
 - b) Perspectives of key stakeholders in the maternity system.
20. The National Maternity Monitoring Group will include the following skill sets or expertise:
 - a) Expertise in epidemiological research and analysis of health data/statistics.

b) Experience and expertise in midwifery care.

c) Experience and expertise in specialist medical maternity care.

d) Experience and expertise in specialist neonatal care.

e) Expertise in Māori health.

f) Expertise in Pacific health.

g) Experience and expertise in representing a consumer perspective on maternity issues.

21. All members of the National Maternity Monitoring Group will have basic skills and confidence in working with and interpreting health data.
22. The Ministry will seek nominations from relevant organisations and professional colleges, including the Health Quality and Safety Commission. The Ministry reserves the right to appoint more than one member from an organisation or college or to appoint members not officially nominated by an organisation or college, in order to ensure the balance of skills and expertise outlined in 20 a) to f).
23. Members of the National Maternity Monitoring Group will share a commitment to working collaboratively and constructively to oversee the national maternity system.
24. The National Maternity Monitoring Group may identify that additional skills or expertise in a particular field or specialty is required to deliver aspects of the agreed work programme. The National Maternity Monitoring Group may seek additional (co-opted) members to fill skill gaps. This will be done in agreement with the Ministry of Health.
25. At least one representative of the Ministry of Health will attend meetings in an ex-officio capacity.

Term of the National Maternity Monitoring Group

26. The National Maternity Monitoring Group will operate until the end of June 2016 unless otherwise notified by the Director General of Health.

Decision-making

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

Appointment process

28. The Director General of Health will appoint members to the National Maternity Monitoring Group.
29. Membership of the National Maternity Monitoring Group will be for a period of three years to June 2016.
30. A Chair and Vice Chair will be elected by the members of the National Maternity Monitoring Group for a term of one year and may be re-elected.
31. Co-opted appointments may be proposed by the National Maternity Monitoring Group and will be made by the Director General of Health.
32. Any member of the National Maternity Monitoring Group may at any time resign as a member by advising

the Ministry of Health in writing.

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

Support for the National Maternity Monitoring Group

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

Meeting arrangements

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

Payment of meeting fees and travel costs

36. A fee of \$325.00 (exclusive of GST) will be paid for attendance at face-to-face meetings and is based upon a full day meeting including travel time. Other work carried out as part of the National Maternity Monitoring Group will be reimbursed on a pro rata basis at the rate of \$325.00 per day (exclusive of GST).
37. Public servant/state servants/employees of Crown bodies are not paid for meetings of the National Maternity Monitoring Group. A public servant/state servant/employee of a Crown body should not retain both the fee and their ordinary pay where the duties of the outside organisation are undertaken during ordinary department or Crown body hours.
38. Payment of meeting and other fees will be in accordance with the latest Cabinet circular on fees and guidelines for appointments for statutory bodies, which can be found at: <http://www.dpmc.govt.nz/sites/all/files/circulars/coc-12-06.pdf>
39. Travel to meetings and, if necessary, flights and accommodation will be arranged. Meal expenses (without alcohol) will also be paid, but other hotel charges including phone calls and items from the 'mini bar' will not be paid. Any additional travel expenses incurred will be reimbursed, including taxis, mileage (at the rate of 0.62c per km, GST not applicable) and parking. A valid receipt must accompany claims for expenses.

Conflicts of interest

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

Confidentiality

41. The National Maternity Monitoring Group will maintain

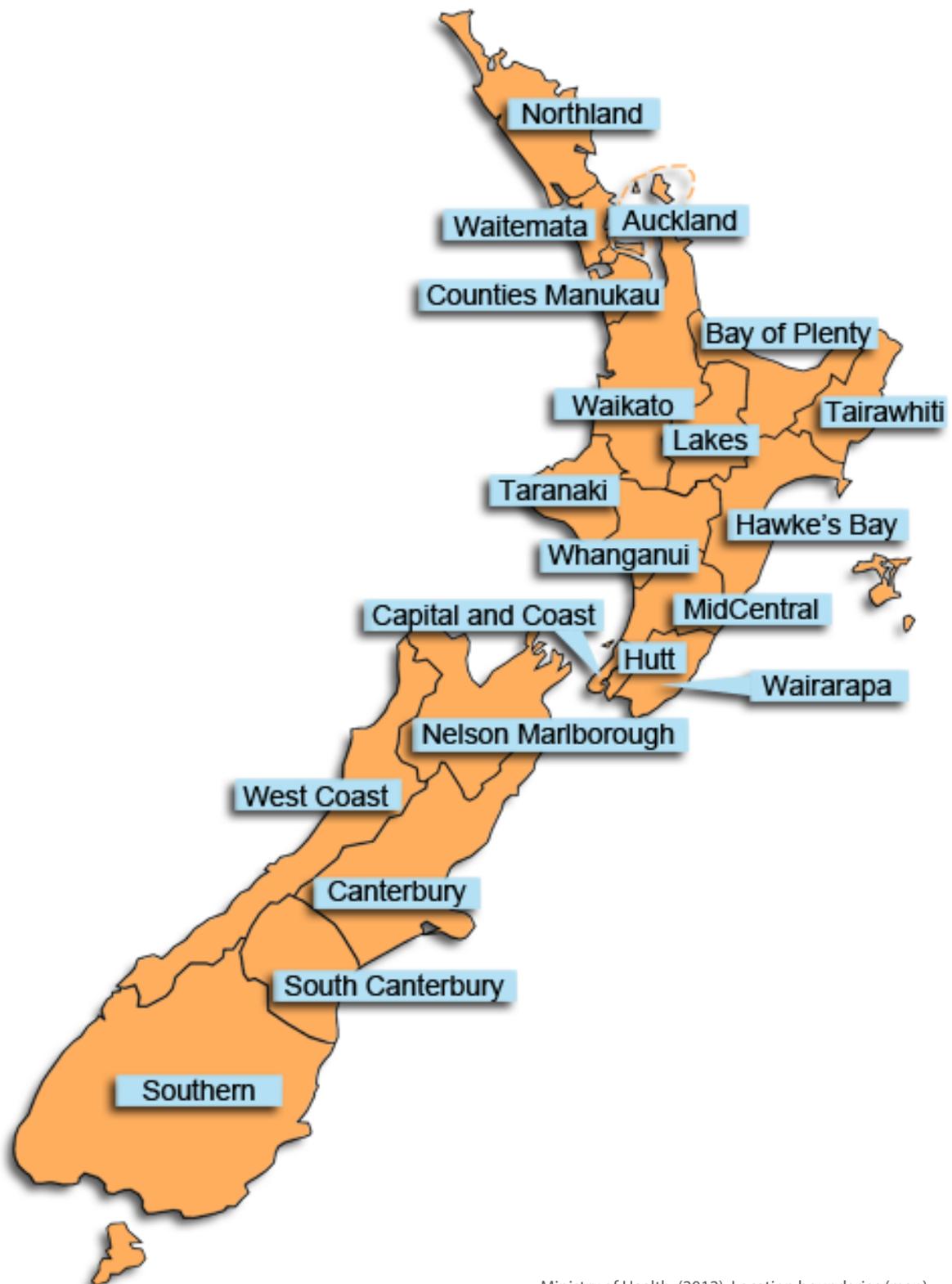
confidentiality of agenda material, documents and other matters forwarded to them unless otherwise specified.

42. Members of the National Maternity Monitoring Group are not to represent themselves as agents of the Ministry of Health, and by reason of their membership of the National Maternity Monitoring Group, are not permitted to speak on behalf of the National Maternity Monitoring Group or the Ministry of Health.
43. If a member receives a media request or enquiry relating to the work of the National Maternity Monitoring Group, they must inform the Ministry of Health including the Ministry's Health Communications Manager. Any media communication will be via the Ministry of Health.

Appendix Two: NMMG Year Two Work Programme

	2013						2014					
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Identify priorities for action or investigation	✓	✓										
Timing of Registration with an LMC												
Retrieve data		✓	✓	✓	✓							
Communicate with DHBs					✓	✓	✓	✓	✓			
Provide recommendations											✓	✓
Variation in Gestation at Birth												
Retrieve data		✓	✓	✓	✓							
Investigate data					✓	✓	✓	✓				
Provide recommendations								✓	✓	✓	✓	✓
Primary Maternal Mental Health Services												
Retrieve data					✓	✓	✓	✓				
Communicate with DHBs and Colleges								✓	✓	✓	✓	
Provide recommendations											✓	✓
Primary Maternity Ultrasounds												
Retrieve data		✓	✓	✓	✓							
Consider data					✓	✓	✓	✓				
Provide recommendations									✓	✓	✓	✓
Connecting with Maternity Consumer Representatives												
Communicate with consumer representatives on MQSP		✓	✓	✓	✓							
Consider findings					✓	✓	✓	✓				
Communicate with DHBs						✓	✓	✓	✓	✓	✓	
Provide recommendations											✓	✓
The New Zealand Maternity Clinical Indicators												
Review the New Zealand Maternity Clinical Indicators 2012						✓	✓	✓				
Communicate with DHBs								✓	✓	✓	✓	
Provide recommendations											✓	✓
Other Reports												
Review the Ministry of Health Annual Report on Maternity publication					✓	✓	✓	✓				
Review and provide feedback on the draft DHB MQSP Annual Reports									✓	✓	✓	✓
Produce a NMMG Annual Report											✓	✓

Appendix Three: Map of NZ DHBs



Ministry of Health. (2012). Location boundaries (map). Reprinted with permission from the Ministry of Health.

List of Definitions

Caesarean section	An operative birth through an abdominal incision.
Elective caesarean section	An elective caesarean is defined as a caesarean section carried out as a planned procedure before the onset of labour or following the onset of labour, when the decision was made before labour. It does not include caesarean section after failed trial of scar.
Emergency caesarean section	An emergency caesarean is defined as a caesarean required because of an emergency situation (e.g. obstructed labour, fetal distress). It is best described as 'when the caesarean section is performed having not been considered necessary previously'. Caesarean section after failed trial of scar would be an emergency caesarean section.
Parity	Number of previous births a woman has had.
Primary health care	The first-contact professional health care received in the community, usually from an LMC, GP or practice nurse.
Secondary health care	Specialist care that you may be referred to by a primary health care professional. These services are usually hospital-based.
Standard primiparae	A group of mothers considered to be clinically comparable and expected to require low levels of obstetric intervention.
Tertiary health care	Highly specialised consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment.
Weeks' gestation	The term used to describe how far along the pregnancy is. It is measured from the first day of the woman's last menstrual cycle to the current date.

List of Abbreviations

CARES	Coordinate Access Response Electronic System	LMC	Lead Maternity Carer
DHB	District Health Board	MQSP	Maternity Quality and Safety Programme
GP	General Practitioner	NMMG	National Maternity Monitoring Group
GROW	Gestation Related Optimal Weight	PMMRC	Perinatal and Maternal Mortality Review Committee
HDU	High Dependency Unit	PHO	Primary Health Organisation
ICU	Intensive Care Unit	VBAC	Vaginal birth after caesarean

Data

Sources Used

National Maternity Collection

- Percentage of Women Registered with an LMC in the First Trimester, by DHB of Domicile, 2011 & 2012
- Elective Caesarean Deliveries as a Percentage of Total Deliveries in Each DHB, 37-39 weeks' gestation, 2012
- Induction of Labour Performed as a Percentage of Total Deliveries in Each DHB, 37-39 weeks' gestation, 2012

The Ministry's National Maternity Collection includes data from hospital birth records and claims made by Lead Maternity Carers. This dataset includes hospital and home births. This dataset allocates year as year of registration with an LMC.

Please note that this data is provisional as at the time of extraction not all not all privately funded hospital discharges (primary birthing units) had been loaded into the National Minimum Dataset (NMDS) for the 2012 calendar year. As the NMDS is one of the key sources of data for the National Maternity Collection (MAT), it is possible that MAT might still be missing some deliveries in 2012, specifically those taking place in primary birthing units that did not have an associated LMC claim.

Section 88 Claims, Ministry of Health

- Ultrasounds Scans per Pregnant Woman, 2011/2012
- Average Number of Scans per Pregnant Woman, 2005/06 to 2011/12
- Average Number of Scans per Pregnant Woman, by DHB of Domicile, 2011/12

The Ministry receives a claim for every ultrasound carried out under Section 88 of the Primary Maternity Services Notice 2007. This allows providers to be reimbursed. These claims are recorded by financial year of due date or actual date of birth. This captures all scans for a pregnancy even when they are distributed across two financial years.

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