NATIONAL MATERNITY MONITORING GROUP

2019 WORK PROGRAMME

BACKGROUND

The National Maternity Monitoring Group (the NMMG) provides strategic advice to the Ministry of Health on priorities for improvement to the maternity system and the implementation of the New Zealand Maternity Standards.

This document outlines the NMMG's work programme for the 12-month period from January to December 2019. To deliver this work programme, we expect to meet quarterly (February, May, August, and November).

STRATEGIC CONTEXT

The NMMG's work is guided by the priorities set out in the New Zealand Health Strategy[1], the accompanying Roadmap of Actions[2], the New Zealand Maternity Standards and the Maternity Quality Initiative (MQI).

The New Zealand Maternity Standards[3] 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.
- 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.

The MQI, refocused in 2015, contains four key priorities:

- Strengthening maternity services including more timely access and more equitable access to community-based primary maternity care and services;
- Better support for women and families that need it most, including better health and social support for young mothers and for maternal mental health and support for improving health literacy among vulnerable populations;
- Embedding maternity quality and safety including further support for local clinical leadership and review, and meeting the Ministry's obligations under the New Zealand Maternity Standards; and
- Improving integration of maternity and child health services including improving transitions between health services through improved communication, coordination and use of information technology.

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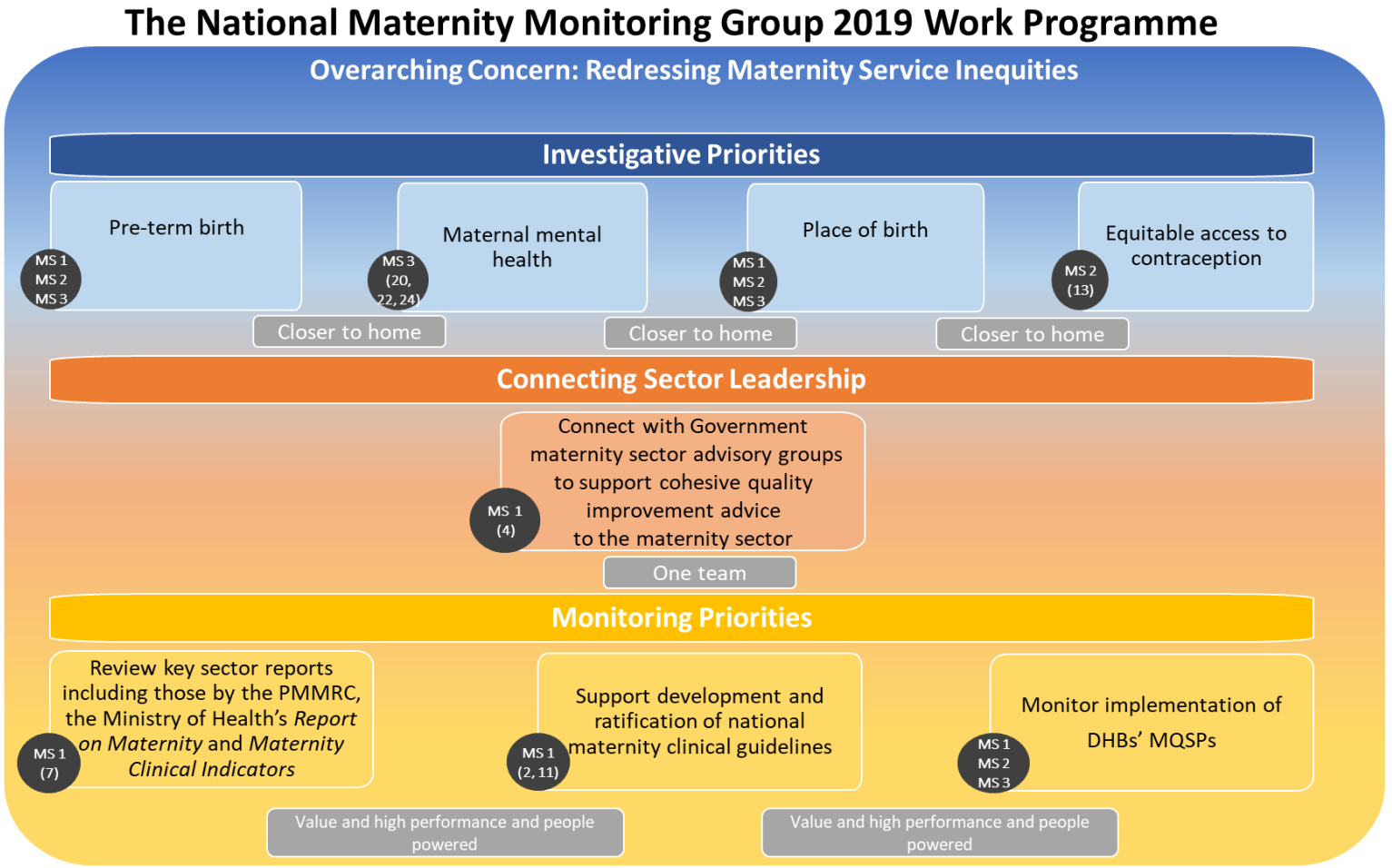
[1] Minister of Health. 2016. New Zealand Health Strategy. Wellington: Ministry of Health.
[2] Minister of Health. 2016. New Zealand Health Strategy: Roadmap of actions 2016. Wellington: Ministry of Health.
[3] Ministry of Health. 2011. New Zealand Maternity Standards. Wellington: Ministry of Health.

SUMMARY

Our work programme for 2019 aligns to the priorities set out in the New Zealand Health Strategy and Roadmap of Actions as well as continuing previous workstreams where further work is required. A summary of our work programme is provided below, noting the connection with specific New Zealand Maternity Standards and Audit Criteria (bracketed).



OVERARCHING CONCERN: REDRESSING MATERNITY SERVICE INEQUITIES

INEQUITY IS NOT INEVITABLE: INEQUITY IS UNACCEPTABLE

EVERYONE IS ENTITLED TO CULTURALLY RESPONSIVE CARE

INVESTIGATIVE PRIORITIES

To continue progress towards achieving maternity standards 1, 2 and 3 and reducing inequity we aim to focus on four investigative priorities for 2019:

- Preterm birth;
- Maternal mental health;
- Place of birth; and
- Equitable access to contraception.

Preterm birth

THE NMMG AIMS TO REDUCE PRETERM BIRTH RATES AND TO REDUCE DEATH AND INFANT MORBIDITY RELATED TO PRETERM BIRTH.

The World Health Organisation defines preterm birth as being babies born alive before 37 weeks of pregnancy are completed. Complications associated with preterm birth are the leading cause of death among children under 5 years of age. Three-quarters of these deaths could be prevented with current, cost-effective interventions. A significant inequity is the lack of follow up and school readiness.

In 2019 we will:

- **request** DHBs to report on:
  - current activities to reduce preterm birth and associated inequities, and follow up services and attendance rates (including by ethnicity);
  - processes in place to follow up women with previous preterm birth (noting this is a major risk factor for preterm related perinatal death); and
  - processes in place to ensure early engagement of women with a midwife.
- **collate** the work being undertaken in the area of prevention of preterm birth and preterm related perinatal death in New Zealand within the last 5 years.
- **advise** the Ministry on recommendations to address the prevention of preterm birth and preterm related perinatal death.

- **champion** a national programme to reduce preterm birth and preterm related perinatal death, with the aim to:
    - reduce inequities associated with preterm birth – appropriate service provision for priority populations, e.g. continuous improvement of cultural competency areas across maternity sector, especially local populations – Māori, Pasifika, Indian, equitable access to early pregnancy care with a focus on identification of modifiable risk factors for preterm birth; and
    - advocate for mandatory cultural competency workshops across the maternity sector to help to redress the health inequities experienced by Māori, Pasifika and Indian mothers and their babies.

Maternal mental health

ALL NEW ZEALAND WOMEN NEED EQUITABLE ACCESS TO APPROPRIATE MENTAL HEALTH SERVICES DURING PREGNANCY AND POSTPARTUM.

Women with existing mental health issues are at risk of mental health issue escalation during pregnancy and in the postnatal period. For some women, access to and provision of mental health services during and after pregnancy is essential to their safety and the safety and wellbeing of their babies. Women remain vulnerable to poorer mental health outcomes (including postnatal depression and suicide) up to one-year postpartum. In the eleventh Perinatal and Maternal Morbidity Review Committee (PMMRC) report, the PMMRC noted that suicide "*continues to be the leading single cause of maternal death in New Zealand.*" New Zealand's rate of maternal suicide is seven times higher than of the United Kingdom. Māori women experience an increased risk of suicide and are over-represented in the number of maternal suicides. Improving access to primary mental health services for all women, and ensuring that services are available for serious and acute episodic mental illness are important ways to support mothers in the first year postpartum, to build wellbeing and live healthy lives for themselves, their babies and their whānau.

In 2019, we will:

- **request** DHBs to report on mental health referral and treatment pathways, asking:
    - what are the criteria for admission to a secondary care service?
    - what proportion of referrals are accepted or declined due to lack of service provision or because they would be more appropriately managed in the community?
    - what facilities are available for inpatient care, and is there provision for babies to stay if appropriate?
    - what challenges are making pathways difficult?
    - what is the extent of unmet need? (via MMPO: College owns the data)
    - how is primary care being supported to manage women with mild to moderate depression during pregnancy and postpartum?

- what measures are being taken to ensure all women (and particularly those at increased risk) are being screened for mental wellness during pregnancy and postpartum?
- are mechanisms being implemented that raise awareness/deliver education among midwives so they feel safe/confident to discuss/address mental health wellness with women and their whanau?
- what systems are in place to ensure midwives/maternity health services are well supported, particularly those midwives who have consistently looked after women with complex mental health unwellness, who are experiencing suicidal tendencies, or who have committed suicide?

- **ask** DHB Planning & Funding divisions to advise what percentage of their mental health budget is allocated to providing maternity mental health services;
- **seek** to include a question about maternal mental health in both the next Maternity Consumer Survey (last conducted in 2014) and the next Survey of Bereaved Women (last conducted in 2015); and
- **ask** Primary Health Organisations (PHOs) what services are available for maternal mental health.

Place of birth

THE NMMG SUPPORTS STRENGTHENING PRIMARY MATERNITY SERVICES INCLUDING TIMELY, EQUITABLE ACCESS TO COMMUNITY-BASED PRIMARY MATERNITY CARE.

Approximately ten percent of New Zealand women birth at primary maternity facilities, with many of these maternity units located in rural areas. Rates of birth at primary facilities are decreasing: the number of women birthing at primary birthing units declined from 15.1 percent in 2006, to 9.9 percent in 2015. Evidence shows that, for a healthy woman and baby with no complications and low risk, birthing at primary birthing units "is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit."

Intrapartum Care for Healthy Women and Babies | Guidance and Guidelines | NICE," accessed May 31, 2018, https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth.

In 2019, we will:

- **develop** an expectation that women will deliver in the environment most suitable to their health and safety needs;
- **promote** the provision of appropriate services so that parents feel safe to deliver in non-hospital environments;
- **highlight** the importance of parents receiving evidence-based information to inform their preferences about place of birth;
- **request** DHBs, PHOs, and the Midwifery Council of New Zealand to report on:
  - how women are informed of the full range of place of birth options, and
  - outline methods used to promote primary birthing facilities;

- **encourage** the Ministry to include in the next Maternity Services Consumer Satisfaction Survey a question relating to how accurately and completely women are informed of place of birth options;
- **gather** workforce information on the numbers of LMCs who are not happy to work in primary birthing units and why (e.g. not feeling confident to work outside a secondary care facility or having to attend different locations to care for their women);
- **request** DHBs to report on what supports are in place to encourage LMCs to birth their women at primary care facilities? (e.g. provision of free PROMPT courses/facilitating registrations); and
- **advocate** for recognition in the codesign process of the increased responsibility of birthing women in a primary care facility.

Equitable access to contraception

ALL WOMEN NEED ACCESS TO FREE CONTRACEPTIVE SERVICES FROM THE IMMEDIATE POSTPARTUM PERIOD.

95% of women who are living in low or middle-income countries and have given birth in the past year hope to avoid a pregnancy in the next two years, but only about one third of these women are using contraception.[1] New Zealand women living in low and middle-income neighbourhoods likely experience similar circumstances. Further, a birth-to-pregnancy interval of less than 12 months is associated with the highest risk of adverse health outcomes for the mother and child.[2] Contraception, enabling spacing of pregnancies, therefore has a vital part to play in reducing adverse health outcomes for mothers and babies.

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

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

In 2019 we will:

- **request** DHBs to report on access to postnatal contraception for all women, including:
  - what percentage of women have a contraception plan as part of their birth plan?
  - what services are being provided to meet the contraceptive needs of women prior to discharge from hospital or from a primary birthing unit, and how well does this service meet the demand?
  - what percentage of women leave a birthing unit with contraception?
  - what percentage of women leave a birthing unit with a LARC?
  - if a LARC service is provided for postnatal women in the community, what percentage of women are referred to this service, and what percentage access it? To what extent is the service reaching Māori and Pasifika women and women under 25 years of age?
- **request** DHBs to report on processes for supporting women to make informed choice and services available that support women to enable their choice of contraception;

- **write** to PHARMAC requesting that Mirena be funded for contraception;
- **investigate** equity of access to LARCs by reviewing information from DHBs about availability and funding of LARCs, exploring and promoting examples of good practice where DHBs ensure equity of access to LARCs for all consumers, including groups of women with poorer maternity outcomes; and
- **monitor** the Ministry's progress towards introducing postnatal contraception on its work programme.

CONNECTING SECTOR LEADERSHIP

Connect with government maternity sector advisory groups to support cohesive quality improvement advice to the maternity sector

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

In 2019, the NMMG will provide strategic leadership to the maternity sector, to drive and create change and improve maternity outcomes. We will:

- **work** with the Ministry to progress the Ministry's consideration of any maternity advisory groups' recommendations (including supporting the implementation of all recommendations made by the Maternity Ultrasound Advisory Group);
- **meet** with DHB Chief Executives at least annually to strengthen visibility of maternity services with DHB executive leadership teams;
- **receive** regular updates on work programmes and any recommendations made by the PMMRC, the MSAG and the NE Taskforce, and the New-born Clinical Network where relevant;
- **monitor** how DHBs respond to any recommendations made by the PMMRC and its subcommittees, the NE Taskforce, and MSAG within Maternity Quality and Safety Programmes (MQSPs);
- **encourage** government maternity advisory groups to coordinate information requests to DHBs and professional colleges;
- **consider,** in collaboration with other groups**,** if a maternity target is appropriate, and if so, what the target(s) could be; and
- **encourage** the adoption or development of a mechanism for prioritising recommendation to DHBs.
- **engage** with the Ministry to determiner the governance of the maternity work programme.

MONITORING ACTIVITIES

Review key sector reports

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

The NMMG will continue to monitor key sector publications. In 2019, we will:

- **review** the *2017 New Zealand Maternity Clinical Indicators* and the 2016 *Report on Maternity* to:
  - **consider** the performance of the maternity system overall;
  - **share** our findings with and **seek** advice from each DHB on any identified significant and consistent variations from the national average and the DHBs' responses to these (including where DHBs are performing well); and
  - **advise** the Ministry of Health, DHBs and other government maternity sector advisory groups on national and local priorities for action; and
- **review** the PMMRC's annual report, providing advice to the Ministry about any notable findings or recommendations (*NB also see the maternal mental health investigative priority)*.

We expect DHBs to also review these reports and consider how presented data applies to the services provided in their areas. We would like DHBs to use their MQSP annual reports to describe how they respond to any recommendations made in these key sector reports.

Monitor the implementation of DHBs' Maternity Quality and Safety Programmes

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

The NMMG will continue to support the Ministry of Health to monitor the implementation of DHBs' MQSPs. In 2019, we will:

- **give** clear direction to DHBs on the reporting expectations by providing a template.
- **review** each DHB's MQSP 2019 Annual Report to determine if and/or how each DHB:
  - articulated its priorities for maternity services and its progress towards these;
  - responded to recommendations made by key maternity sector advisory groups;
  - published its report online;

- implemented changes to align processes and procedures to the hypertension guideline released by the Ministry of Health;
- monitored rates of women diagnosed with eclampsia during birth admission and, if an increase was identified, investigated possible reasons for the rise[4];
- undertaken continued efforts to ensure elective caesareans are not completed prior to 39 weeks gestation; and
- alignment with NMMG investigative priorities of preterm birth, maternal mental health, place of birth and equitable access to contraception.

- **engage** with DHB maternity governance teams to discuss their maternity service performance
- **support** the Ministry to review the DHB MQSP Crown Funding Agreements and implement any changes if required;
- **review** any external reviews of DHB maternity and women's health services to determine key themes, **share** findings with DHBs and other key sector stakeholders, and **monitor** the DHB's implementation plan to address recommendations made in an external review; and
- **monitor** how Counties Manukau, MidCentral/Whanganui, Waikato and South Canterbury DHBs have responded to and implemented the recommendations set in their external reviews.

Support development and ratification of national maternity clinical guidelines

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

In 2019, we expect to ensure that national evidence-informed clinical guidance is appraised and ratified using the AGREE II Instrument and algorithm. We will:

- **consider** draft material for ratification as national guidelines (as required);
- **write** to DHBs requesting information about how they have implemented the *'Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand: A clinical practice guideline'*;
- **champion** the development of a guideline on the induction of labour (as per the PMMRC's 2017 recommendation to develop a national interdisciplinary clinical practice guideline on the indications and timing of induction of labour);
- **champion** the development of a National Preterm Birth guideline; and
- **recommend** the Ministry allocate funding to prioritise updating the New Zealand Maternal Fetal Medicine Network (NZMFM) small for gestational age (SGA) guideline.

[4] Eclampsia is a serious condition that is largely preventable through the detection and effective management of pre-eclampsia. Rates of eclampsia at birth admission have increased since 2010. It is important for DHBs to identify and investigate the reasons for eclampsia at birth admission.