Maternity Services (District Funded)

Primary Maternity Facility

Previously known as the MATERNITY SERVICES –DHB-FUNDED PRIMARY MATERNITY FACILITY

Tier 2

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑ RECOMMENDED ☒

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
Published on NSFL	**July 2013**
Review: of the Maternity Facility Service Specification (December 2003) Reviewed to reflect current status and requirements for DHB-funded Primary Maternity Facilities. Aligned with the New Zealand Maternity Standards and provides guidance to DHBs in implementing the Maternity Quality and Safety programme.	**March 2012**
Amendments: New purchase units W02020 and ADJ118, retired W02009, ADJ117 and revised Appendix One: Relative Value Unit Methodology for Inpatient Maternity Care in DHB Funded Primary Maternity Facilities with Relative Value Unit table (as per Casemix Rules published on http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/national-collections-annual-maintenance-project/ncamp-2013-supporting-documents).	**June 2013**
Content moved to updated Health New Zealand format	**September 2024**
Consideration for next Service Specification Review to address administrative clarifications that may become apparent once the new service specification is in operation and Ministry of Health intention to review the RVU formula every two years.	**Within two years**

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, to discuss the process and guidance available in developing new or updating and revising existing service specifications. Web site address Nationwide Service Framework Library: Nationwide Service Framework Library – Health New Zealand

3. Introduction

This Tier Two service specification applies to all District-funded primary maternity facilities. It must be used in conjunction with the Tier One Maternity Services - District-funded Service Specification.

This service specification also links with:

- other tier two service specifications for maternity services including: Secondary and Tertiary Maternity Services and Facilities, District-funded Primary Maternity Services, and Pregnancy and Parenting Education
- the Primary Maternity Services Notice 2007, pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 (the Primary Maternity Services Notice).

Refer to the Tier One service specification headings for generic details on:

- Service Objectives
- Service Users
- Access
- General Service Components
- Service Linkages
- Exclusions
- Quality Requirements

The above sections are applicable to all service delivery.

4. Service Definition

The Primary Maternity Facility provides a physical setting for assessment, labour and birth, and postnatal care. It may be a stand - alone facility or unit within a Level 1 or 2 general hospital as defined in the New Zealand Role Delineation Model. The Primary Maternity Facility, in conjunction with the Lead Maternity Carer (LMC) or District-funded Primary Maternity Services Provider, provides primary maternity inpatient services during labour and birth and the postnatal period until discharge or transfer (the Service). Primary Maternity Facilities have no inpatient Secondary or Tertiary Maternity Services as described in the Tier one service specification.

5. Service objectives

For general objectives, see the service specification for Maternity Services Tier One. The specific objective of the Service is to provide an inpatient maternity service as close to home as possible to allow women to have choice about the setting for non-complex births.

6. Service Users

Eligible women have access to District - funded primary maternity facilities during labour and birth and the postnatal period until discharge or transfer.

7. Access

7.1 Entry Criteria

You will provide access to the Facility for each woman who:

a. has a LMC, and that LMC has an Access Agreement[1] with the Facility; or

b. has a GP or obstetrician LMC who has an Access Agreement and has made a prior arrangement with the Facility to utilise midwifery services provided by the Facility, or as per the District-funded Primary Maternity Services Tier Two service specification

c. has a District-funded LMC or District-funded Co-ordinated Midwifery Care[2]

d. presents acutely, including pregnant women for assessment, in labour, or:

- who does not have an LMC or District-funded Primary Maternity Services Provider
- is not able to contact their LMC or the LMC's backup, or their District-funded Primary Maternity Services Provider
- has been transferred from another maternity facility in accordance with agreed timeframes and funding arrangements.

7.2 Exit Criteria

Exit from the Service occurs:

a. on discharge from the Facility; or

b. if there is a transfer of woman and / or baby (either planned or emergency) to another maternity facility.

8. Service Components

8.1 Settings

A Facility will have sufficient assessment, birth and postnatal rooms for the population serviced by primary maternity services, and for the level of service provided. It will include, but is not limited to, adequate facilities, equipment and consumables for:

a. LMCs to undertake acute clinical consultations or examinations

b. monitoring progress of labour and assisting with births

c. emergency resuscitation and care of mother until transfer of care to secondary or tertiary services if necessary; and

[1] See clause 5.2 below.
[2] See the specification for District-funded Primary Maternity Services Tier Two.

d. emergency resuscitation and care of the newborn until transfer of care to neonatal services, if necessary, including equipment to maintain baby body warmth.

e. newborn hearing screening, in accordance with any requirements of the Universal Newborn Hearing Screening Programme.

8.2 Access Agreements

You will use the Access Agreement contained in Schedule 3 of the Primary Maternity Services Notice to set the terms and conditions of access to a Facility for LMCs funded under the Primary Maternity Services Notice.

8.3 Labour and birth within a primary maternity facility

- You will provide urgent antenatal assessment and care as clinically required by a woman who:
  a) does not have an LMC
  b) is not able to contact their LMC or their LMC back up, or
  c) is awaiting arrival of their LMC or their LMC back up.
- When a woman who has registered with an LMC arrives at a Facility in labour, You will:
  a) notify the LMC of the woman's arrival at the Facility (although it is expected that the woman will contact the LMC directly);
  b) provide care according to the woman's needs, until the LMC arrives
  c) be available to provide occasional support when requested by the LMC and in negotiation with Facility staff; and;
  d) provide physical assistance, if required.
- Where a woman who has not registered with an LMC arrives at a Facility in labour, You will arrange for labour, birth and postnatal services to be provided either by an LMC funded under the Primary Maternity Services Notice, or by a Midwife who is employed or funded by You.
- You will ensure that a Midwife is available either on-site or on-call 24 hours per day, 7 days per week to provide support to the LMC (or to the LMC's back-up or other practitioner delegated to provide care in accordance with the Primary Maternity Services Notice).
- You will supply midwifery support to enable the LMC to have appropriate rest periods in negotiation with staff employed by You.
- There will be no epidurals or caesarean sections at a Facility. A Facility will not use medication to induce labour or augment labour.
- You will provide midwifery care until a woman is clinically ready for transfer to a postnatal ward or other appropriate setting for postnatal care.

8.4 Emergency transfer from community settings and primary maternity facilities to secondary and / or tertiary maternity services

You will have a formal written policy for management of emergencies, which includes the procedure for emergency transfers from the Facility to a Secondary and / or Tertiary Maternity Service. Your formal written policy will be in accordance with the Maternity Referral Guidelines.

Your formal written policy for management of emergencies, as described in the Maternity Referral Guidelines, will include:

a. an immediate response by an appropriate practitioner to assist the LMC or District-funded Primary Maternity Services Provider to provide advice, including by telephone

b. ensuring all health practitioners and staff who use the Facility know how to request an emergency transfer using the national 111 answering facility and triage service;

c. ensuring all health practitioners and staff who use the Facility know how to request/access immediate advice from an appropriate practitioner in a Secondary and/or Tertiary Facility, including by telephone;

d. contacting other local health practitioners who may be able to provide assistance in an emergency; and

e. facilitating with emergency ambulance services the availability of effective and timely emergency ambulance services.

When emergency ambulance services are used, the costs of the emergency transfer from the Facility to a secondary and / or tertiary maternity facility is met through the Ministry of Health's national contract for emergency ambulance services. This includes the provision of land, water, and air emergency ambulance services[3].

Where an LMC funded under the Primary Maternity Services Notice has clinical responsibility for the woman and / or her baby and the woman and / or her baby is being transferred to a secondary or tertiary maternity facility, the LMC is responsible for providing the escort during the transfer.

Where You have clinical responsibility for the woman and / or her baby, and the woman and / or her baby is being transferred to a secondary or tertiary maternity facility, You are responsible for providing an appropriately qualified escort during the transfer.

[3] The Emergency Ambulance Services may charge a co-payment to the consumer for emergency ambulance transport from the community setting or primary maternity facility to a secondary and/or tertiary maternity facility

8.5 Inpatient Postnatal Care

You will provide Midwives to supply 24 hours per day, 7 days per week postnatal care (or Nurses with a Midwife available on-call).

The Inpatient Postnatal Care provided by You will include:

a. midwifery care for mother and baby in accordance with the woman's written Care Plan and as directed by the woman's LMC or District-funded Primary Maternity Services Provider

b. contacting the LMC to inform her / him of any adverse changes in the well-being of mother and / or her baby or transfer within the hospital or to another hospital

c. assistance with feeding the baby, following establishment of the first feed in accordance with the requirements of the Baby Friendly Hospital Initiative (BFHI); including infant formula where clinically indicated

d. prescription, provision and administration of medication and blood products, including that prescribed by the LMC or the District-funded Primary Maternity Services Provider

e. parenting education in liaison with the LMC or the District-funded Primary Maternity Services Provider

f. emergency care, if required; and

g. assistance with any planned postnatal transfer to another maternity facility, or discharge.

8.6 Postnatal Stay and Discharge from a Primary Maternity Facility

The LMC (or, where the woman does not have an LMC, the District-funded Primary Maternity Services Provider) will determine when the woman is clinically ready for discharge, in consultation with the woman and the Facility. The LMC (or, where the woman does not have an LMC, the District-funded Primary Maternity Services Provider) will identify reasons for a postnatal stay greater than 48 hours

The reasons for a postnatal stay longer than 48 hours may include:

a. breastfeeding problems

b. post-operative recovery

c. ongoing medical problems

d. psychological problems

e. babies with special needs

f. geographical isolation

g. women who need to gain confidence in caring for their baby.

8.7 Processes prior to discharge from Primary Maternity Facility

Where the woman does not have an LMC funded under the Primary Maternity Service Notice, or has not previously accessed a District-funded Primary Maternity Services Provider, You will have a mechanism for ensuring that prior to the mother and baby's discharge from the Facility, or the baby's transfer to a neonatal service:

a. arrangements are made with either an LMC funded under the Primary Maternity Service Notice or with the District-funded primary maternity service to provide postnatal midwifery care; and

b. sufficient information is gathered for registration on the National Immunisation Register (NIR) including:

   i. a full and accurate record of birth details to enable valid NIR registration including the names of the Well Child provider and General Practitioner; and

   ii. information of any vaccination given to the newborn.

8.8 Inpatient Key Inputs

You will supply:

a. clinical consumables such as medications, sterile fluids and blood products as prescribed to the mother and baby; and Ancillary Services, including sterile supplies and infection control

b. hotel services that include the provision of bed linen, towels, liners for birthing pools, patient meals, clinical and non-clinical consumables such as, nappies, toilet paper and sanitary pads sufficient for the entire period of stay

c. housekeeping and cleaning services for the Facility and equipment

d. administrative support for the electronic collection of clinical data required for admission and discharge processes, and submission to the National Maternity Collection. This administrative support will be provided to all health practitioners using the Facility, including practitioners not employed by the District or the Facility.

9. Service Linkages

For the purpose of clarifying service boundaries, the Service provided by the Facility is linked to, but does not include the following:

Other Services	Nature of Linkage	Accountabilities
Primary Maternity Services, funded by Districts as well as those funded under the Primary Maternity Services Notice	Liaison and consultation processes. Maintain linkages with local medical LMCs who arrange to use facility midwifery services.	The District-funded Primary Maternity Service is interdependent with LMC services funded under the Primary Maternity Services Notice. Establish relationships with District-funded Primary Maternity Service and LMC services funded under the Primary Maternity Services Notice. Where a medical LMC requires access to hospital midwifery services, a prior agreement with a maternity facility on the use of its hospital midwifery services must be made.
Secondary Maternity or Tertiary Maternity Services and Maternity Facility Services and any other related services within the District's provider arm	Liaison and consultation processes.	Clinical consultation and referral services that support continuity of care.
Emergency Services	Liaison and consultation processes.	District-funded primary maternity facilities will establish relationships with local emergency services, including establishing agreed processes for responding to emergencies in primary maternity facilities.
Allied health, including dietician services, physiotherapists, social workers	Liaison and consultation processes.	District-funded primary maternity facilities will maintain linkages and have clear pathways for referrals.
Māori liaison and support workers	Liaison and consultation processes.	District-funded primary maternity facilities will maintain linkages and have clear pathways for referrals.
Grief and loss services	Liaison and consultation processes	Clinical consultation and referral services that support continuity of care, and meet each woman's clinical need.

10. Exclusions

Refer to the Tier One Maternity Services service specification

11. Quality Requirements

The Facility must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

Refer to the Tier One Maternity Services service specification for generic requirements.

12. Purchase Units and Reporting Requirements

Purchase Units are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The Facility must comply with the reporting requirements of national data collections where available.

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	Reporting to National Collections
W02020	Inpatient maternity care primary maternity facility	Primary maternity facility services for a woman during labour, delivery and postnatal stay in a primary maternity facility.	RVU Maternity -	refer to WIESNZ13 for methodology	National Minimum Data Set (NMDS)
ADJ118	District funded primary maternity facility diseconomy adjuster	Price adjuster for small rural primary maternity facilities (more than 30 kms from secondary maternity inpatient service) to reflect additional costs in maintaining service capacity. Only to be used in conjunction with W02020	Adjuster	Price adjustment for cost elements not adequately recognised within national purchase unit base prices.	NNPAC

Note: The District Funded primary maternity facility diseconomy adjuster purchase unit ADJ118 may be used for small maternity facilities in addition to W02020.

Refer to Appendix One, Relative Value Unit Methodology for Inpatient Maternity Care in District Funded Primary Maternity Facilities.

13. Appendix One – Relative Value Unit Methodology

Relative Value Unit Methodology for Inpatient Maternity Care in District Funded Primary Maternity Facilities

Introduction

This Appendix provides guidance for the application of the Relative Value Unit (RVU) for components of services provided by District funded primary maternity facilities for inpatient maternity care.

RVUs are used for counting and analysis purposes by the Ministry of Health. Districts may allocate funding to one or more of the RVU components listed in point 3 below. Districts may adapt and amend this methodology to fit their service delivery purchasing arrangements. Local adaptations of the RVU methodology for funding purposes should be referred to as 'Purchasing Measures'.

Note: For the purposes of nationwide counting consistency, previously used the case weights information for primary maternity facility services will be replaced by the RVU methodology described below when the facility data is supplied to the National Minimum Data Set (NMDS). This will be implemented from 1 July 2013.

Relative Value Unit Methodology

1. A Primary Maternity Facility is any facility funded by a District that provides inpatient maternity care but is not included in the list of casemix facilities at section 5.2.7 in the Casemix Framework document[4]
2. Inpatient maternity care in a Primary Maternity Facility is any event with an outcome of delivery diagnosis code (Z37.0-Z37.9) or a live infant diagnosis code (Z38.0-Z38.8) or a postpartum diagnosis code (Z39.0-Z39.2) in any diagnosis field, or any DRG in the O01A to P67D range.
3. Reporting information to NMDS for primary maternity facilities for components of inpatient maternity care is made on the basis of a Relative Value Unit (RVU). The RVU for maternity inpatient care has the following components:
    - Labour and Birth
    - Labour-only
    - District-funded Lead Midwifery Care for labour and birth
    - District-funded Lead Midwifery Care for postnatal care
    - Per Diem for mother
    - Per Diem for baby.
4. The relative values of these components are listed in Table 1 below.
5. The Ministry of Health will review the RVU formula every two years or within other timeframes decided by the Ministry of Health.

[4] (available at: http://www.nzhis.govt.nz/moh.nsf/pagesns/300/$File/wiesnz11-final20052011.doc#_Toc293646106)

Other events and the Labour-only component

6. The Labour-only component applies to those Primary Maternity Facility events where labour occurs without a birth. This includes events in the DRG range O64x to O66x with a supervision of normal delivery code (Z34.0-Z34.8) in any diagnosis field. These should comprise a small proportion of annual primary maternity activity. Districts may cap the funding for labour-only components.

   To allow for Labour - only events, and the possibility of other types of events not explicitly identified in the RVU table, these "Other" events will be calculated as follows:

   Other care / activity components, where the activity meets conditions described in the Casemix Rules, are calculated at 0.7 of the Mother's per diem RVU.

Labour and Delivery component

7. The Labour and Delivery component applies where birth occurs in a Primary Maternity Facility. This includes events with an outcome of delivery diagnosis code (Z37.0—Z37.9) in any diagnosis field.

District-funded Lead Midwifery Care component

8. The District-funded Lead Midwifery Care component applies where an event is not attended by an LMC who may claim under the Primary Maternity Service Notice. These events are identified by Health Speciality Code P60 in the relevant field of data submitted to the National Minimum Data Set (NMDS). Where the birth is attended by a LMC who may claim under the Notice, Health Speciality Code P70 is used. Facilities should ensure that the correct health speciality code is entered in data submitted to the NMDS. (Note there may be options for post-discharge review of the health specialty code via matched S88 claims data.)

9. Where lead midwifery care is provided by staff employed by an NGO facility, the event should be coded as P70, the Facility or the individual staff may claim the relevant fee(s) under the Notice.

10. If lead midwifery care is provided by District-employed staff in a private or community-run facility, the event should be coded as P60. Cost recovery should be arranged between the District and the facility concerned.

Per Diem Component

11. The Per Diem component is based on the total length of stay in a Facility. The total length of stay is in NMDS is calculated from the date of admission to the date of discharge from a Facility.

12. There is no limit to the length of stay that can contribute to the calculation of an RVU for any one event. However, Districts may decide to place a cap on the total number of days (or hours) stayed, and hence total RVUs, that may be funded during a given time period. Any such limit will be stated in a contractual agreement between the District and the Facility prior to the start of the time period.

13. Districts and Facilities may agree to payment being made on a per-event basis or on a contracted time period.

14. The Per Diem RVU is based on a period of 24 hours. Where the time of admission and time of discharge from a facility are known, Districts may calculate the RVU for a single event or multiple events based on total length of stay in hours. One hour is equivalent to $1/24^{th}$ of an RVU.

Table 1: Components of the Maternity Relative Value Unit (RVU)

Weight Element Components	Weighting Applied to NMDS data
Labour and Delivery	1
Per Diem- Mother	0.542
Per Diem - Baby	0.633
Same Day - Mother[5]	0.380
Same Day- Baby	0.443
District Midwife margin (labour & birth) (stay weighted)	0.565
District Midwife margin (postnatal stepdown) (stay weighted)	0.259

[5] this weight also used for residual activity that fits within the primary maternity facility definition but is not covered by specified components. See 6. Other events and the Labour-only fee, above.