

WIDER CONTEXT FOR THE MATERNITY ACTION PLAN

PMMRC RECOMMENDATIONS

- Promote the Ministry of Health's pregnancy guidelines to Lead Maternity Carers.
- Inform LMCs that bleeding during pregnancy is a possible risk factor for perinatal death.
- Request LMCs to measure fundal height and weight at the first antenatal visit to improve the recognition of infants who are small for gestational age.
- All families who experience a fetal or neonatal death be offered a post mortem examination.
- Improve the provision of perinatal pathology services to ensure quality and equitable access.
- Develop national guidelines for District Health Boards (DHBs) to provide better support to parents, families and whānau around a perinatal death.
- Develop support and information resources for the community.
- Provide timely and robust denominator data on births.
- Support national reporting of maternal deaths, and treat as a rare sentinel event for the purposes of reviewing the quality of the system.
- DHBs to review of all maternal deaths under the auspices of the PMMRC's regional mortality review groups.
- Identify women at risk due to poor maternal mental health, and notes that improved access to maternal mental health services is required across all DHBs.
- Improved communication between primary and secondary services.
- Staff involved in care of pregnant women should undertake regular training in management of obstetric emergencies.
- Each acute obstetric unit develops a massive transfusion protocol to respond to major obstetric haemorrhage.

GOVERNMENT INITIATIVES

- longer postnatal stays
- 3-way visits with woman, LMC & GP for at risk women
- refresher/obstetrics training for GPs
- Voluntary Bonding Scheme
- Rural midwifery recruitment & retention

WELLINGTON MATERNITY REVIEW NATIONAL RECOMMENDATIONS

- Clearly define 'primary', 'secondary' & 'tertiary' in relation to maternity services.
- Clarify rights and responsibilities of LMCs and DHBs in the Access Agreement wording.
- Monitor implementation of the Maternity Action Plan.
- RANZCOG and NZCOM identify the need to work collaboratively to ensure provision of seamless maternity care to women.
- Ensure ongoing funding of Midwifery First Year of Practice programme.
- LMCs informing women of their experience.
- Obstetric registrar training include experience with self-employed or DHB-employed LMC midwife in primary birthing.
- Include information for women on making a complaint.
- Develop national maternity service standards and audit the same.
- Ongoing obstetric education includes regular updating of obstetric emergency skills.
- Ensure strategic plan for maternity services includes direction for quality improvement and risk management.
- Self-employed LMCs to comply with national serious event reporting requirements when developed.
- Ensure provision of comprehensive information to all women receiving maternity services.
- Develop a strategy to ensure Maori and Pasifika women are aware of their choices regarding maternity services.
- Monitor compliance with maternity service standards once developed.

Maternity Action Plan

PROVISION, CO-ORDINATION & INTEGRATION OF MATERNITY SERVICES

GOALS 2, 3, 4 & 5

Government Initiatives 1 and 2
Wellington Review Recommendations 2, 3 and 15

LEADERSHIP GOAL 1

Wellington Review Recommendation

MATERNITY INFORMATION SYSTEMS & DATA COLLECTION GOAL 8

PMMRC Recommendations 8, 9 and 12

MATERNITY WORKFORCE GOAL 10

Government Initiative 3
PMMRC Recommendations 5 and 13
Wellington Review Recommendations 5 and 10

QUALITY & SAFETY GOALS 6 & 7

PMMRC Recommendations 1, 2, 3, 4, 6,7,10, 11 and 14.
Wellington Review Recommendations 1,2,6,8,9,11,12,13, and 14.

INEQUALITIES GOAL 9

RELATIONSHIPS & MULTIDISCIPLINARY COOPERATION GOAL 11

Wellington Review Recommendation 7