

Maternity Action Plan
2008–2012
Draft for Consultation

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Table of Contents

Acknowledgements	iii
Table of Contents	iii
Introduction	1
Background	3
Current Maternity Service Provision	5
Vision	6
Principles	7
Current Issues in Maternity Services	11
Leadership	11
Provision, Integration and Co-ordination of Maternity Care	11
Quality and Safety	11
Maternity Information Systems and Data Collection	11
Inequalities	11
Workforce.....	12
Relationships and Multidisciplinary Co-operation	12
Priorities, Goals and Actions	13
Leadership	14
Quality and Safety	18
Maternity Information Systems and Data Collection	20
Inequalities	22
Maternity Workforce	23
Relationships and Multidisciplinary Co-operation	25
Appendix 1: The Maternity Action Plan in Context	26
Appendix 2: Members of the Maternity Services Strategic Advisory Group	29
Appendix 3: Terms of Reference, MSSAG	31
Part I: Purpose of the Advisory Group	31
Part 2: Terms of engagement	33
Term of Appointment	34

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The Ministry of Health would also like to acknowledge all those who have contributed to the development of this Maternity Action Plan (MAP) and the work already done by individuals, government and non-government organisations and other agencies for the maternity services of New Zealand.

Note:

The information in the Maternity Action Plan does not reflect the views of any individuals or organisations. The Ministry of Health has developed the plan with the assistance of the MSSAG and other stakeholders.

Introduction

In the year to March 2008, there were 63,250 live births registered in New Zealand which is 9.8 percent higher than the average number of births per year over the last 10 years¹.

A high quality maternity service is necessary to ensure a positive influence on the health status and social wellbeing of the woman, baby, family and community. It is essential that maternity services are of the highest quality to ensure optimal outcomes for both women and their babies.

The influences on birthing outcomes for women and their babies are complex and it is important to provide maternity services for women, their babies, partners and families/whānau that are responsive and maximise their opportunity to experience birth as a normal, physiological life event. Maternity services must also provide access to complex and appropriate obstetric and other care when necessary. Measures to improve the percentage of women giving birth normally need to involve families, communities, maternity services, government and non-government groups and agencies.

The Government considers it timely to take stock of current issues in maternity services and current government strategies to plan for the future development of integrated and well co-ordinated maternity services.

The Maternity Action Plan (MAP) is set in the context of existing work and emerging programmes, and establishes the maternity sector as the leader in the protection, promotion and support of birth as a normal life event in this country. The MAP also extends to working across other sectors for a comprehensive approach to maternity services at local, regional and national levels.

It is also important to consider the development of the MAP in the context of other relevant government strategies and programmes of work and these include:

- the use of a population health approach in the planning and provision of health services to identify high need populations and target resources appropriately
- a focus on reducing inequalities which is as a key priority area for government
- the development/reorientation of health services for Māori and Pacific peoples as a government priority in aiming to reduce inequalities
- linking with primary health care services which are the Government's key mechanism for improving the health of the population and reducing inequalities
- integration of health services in a way that ensures the provision of effective and efficient health care.

The MAP has also taken into consideration a number of key initiatives aimed at specifically addressing maternity outcomes:

- the revision of the section 88 Maternity Notice and funding increases in 2007 in recognition of service demand and workloads

1. Statistics New Zealand, Births and Deaths, March quarter 2008.

- the review of education and training of midwives by the Midwifery Council and the extension to the current training programme from 32 weeks to 40 weeks
- introduction and funding of new screening programmes for women and their babies
- the changes implemented in the Coroner's Act revised in 2007 which required specific reporting on maternal and perinatal deaths
- the establishment of the Perinatal and Maternal Mortality Review Committee and the maternal mortality working group
- recommendations that have been made by the Health and Disability Commissioner (HDC) and Coroners over recent years; which are focused on specific changes to service delivery 'at the coal face'
- the 2008 Review of the Quality, Safety and Management of Maternity Services in the Wellington Area which was charged with identifying issues to be looked at in the context of maternity services throughout the country.

The MAP is expected to contribute to longer-term strategic objectives that include:

- improved maternal and infant outcomes
- reduced inequalities
- increased public confidence in the safety and quality of maternity services.

The MAP will have an impact on government services, maternity and other health services and women, their families and communities.

The MAP recognises that it is women² who experience pregnancy, birth and the postpartum period. Every woman also lives in a social environment that includes her baby³, partner and family/whānau. The use of the words woman/women throughout this document is inclusive of babies, partners and family/whānau

2. The New Zealand Government is a signatory to "The convention on the elimination of all forms of discrimination against women", The United Nations General Assembly, 1979.

3. The New Zealand Government is also a signatory to "The convention of the rights of the child", the UN General Assembly, 1989.

Background

Maternity service provision in New Zealand has changed significantly in the last 20 years. Before 1990 all births were required to be supervised by a doctor. General practitioners (GPs) were the point of contact for community maternity services and provided New Zealand women with antenatal care. Some women received their antenatal care from hospital midwives and obstetricians under a hospital-based 'clinic' system. The majority of labour and birth care was provided in maternity hospitals by midwives working rostered shifts; GPs attended for parts of the labour and the birth and obstetricians attended to provide obstetric opinion or actions when intervention was required. Women stayed in hospital for 5 to 10 days after the birth. Once discharged, GPs provided any postnatal care required including a six-weeks postnatal check. On discharge the baby was referred to the well child services. A few midwives provided home birth services and a few women paid for private maternity care from obstetricians⁴.

The provision of maternity care in the 1980s meant that most women using hospital services could see a large number of different maternity providers during their childbirth experience. Women's groups over a period of decades expressed dissatisfaction with maternity services and urged service reform that recognised birth as an event which must involve families more⁵ (Coopers and Lybrand, 1993). Both women and the midwifery profession were vocal in the need to change to a more personalised way of providing maternity care for this pivotal event in the lives of women, their babies, their partners and their families/whānau.

New Zealand developed a unique response to the consumer demand for a more woman and family centred maternity service which has continued to evolve into the system we have today. The introduction of the Nurses Amendment Act 1990 enabled midwives to offer midwife-led care in the community from pregnancy to six-weeks post-partum in addition to care offered by the general practitioner or obstetrician care.

The Lead Maternity Carer (LMC) model was introduced in July 1996 with the change to the Maternity Payments Schedule (MPS). The LMC has overall professional and clinical responsibility for a woman's primary maternity care and is expected to provide continuity-of-care to the woman. This meant that each woman could choose either a midwife, general practitioner or an obstetrician as her LMC. The LMC is responsible for providing or co-ordinating care throughout pregnancy, labour, birth and for six weeks after the birth.

In 1999 the National Health Committee undertook a major review of maternity services and made a number of recommendations. Key recommendations called for the development of a set of national principles and standards to guide all maternity services, means to better monitor the performance of the sector, greater co-operation between the various professionals involved in maternity care and the need to firmly embed primary maternity services alongside other primary care services.

In 2000 the Health Funding Authority (HFA) undertook some further work on reviewing maternity services and to identify a strategic direction ahead of the establishment of district health boards (DHBs). The resulting HFA report noted that the maternity services were essentially sound but that there was a need for refinement and augmentation of the existing

4. Health Funding Authority, Maternity Services: A Reference Document, November 2000.

5. Coopers and Lybrand, First steps towards integrated Maternity Services Framework, 1993.

model. Further work is required to identify the way forward for any recommendations yet to be implemented.

In February 2007 there was a review of the Maternity Facility Access Agreement and changes were made to the Section 88 Access Agreement Notice following consultation with stakeholders.

The Maternity Services Strategic Advisory Committee was convened in October 2007 to take stock of past achievements, current service provision and develop a strategic vision and a Maternity Action Plan for the next five-ten years.

Current Maternity Service Provision

In New Zealand, women mainly receive their maternity care from an Lead Maternity Carer (LMC) who is a midwife, an obstetrician or a GP with a Diploma in Obstetrics or equivalent. Most women register with a midwife LMC (approximately 75%) compared to 5.6% registering with a GP LMC or 6.1% registering with an obstetrician⁶. Maternity care is free in New Zealand to eligible women. An obstetrician LMC can charge women an additional fee for the services they provide in a private capacity. In 2004, most women (97.5%) gave birth in a hospital compared to 2.5% of women who had a home birth⁷. Almost all births in New Zealand have a midwife in attendance either as the LMC or to provide midwifery care when the LMC is not a midwife.

In 2005 about two thirds of women (66.8%) had a normal birth compared to 9.2% of women who had an assisted vaginal birth and 23.7% of women who had a caesarean section. There is a concern by providers and consumers in New Zealand that the caesarean section rate has increased from 11.7% of births in 1988 to 23.7% in 2005, reflecting a worldwide increase in surgical births. Also, caesarean section rates vary significantly around the country⁸.

The 2007 maternity consumer satisfaction survey identified a high level of satisfaction with maternity services. It also identified that there has been an increase in women having difficulty finding an LMC and women who reported that they did not feel ready to leave hospital. The difficulty in finding an LMC is related to current shortage of midwives and the maternity workforce overall. The effect of these shortages, particularly in some parts of the country is compounded by a decrease in the number of obstetricians, particularly in some parts of the country, and to the increase in the number of births⁹.

The following issues have been identified by the Ministry of Health in partnership with the Maternity Services Strategic Advisory Group as requiring action:

- leadership of maternity policy, strategy and service development
- the interface of primary maternity service provision with secondary and tertiary maternity services including funding issues
- alignment of maternity services with primary health care services
- quality assurance issues including maternity service standards and clinical guideline development and/or review
- maternity information systems, data collection and analysis including outcome and performance indicators
- inequalities in maternity outcomes, particularly for Māori and Pacific peoples
- current and future strategies to address workforce issues
- professional relationships and multidisciplinary co-operation.

6. Ministry of Health, Maternity Report, 2004.

7. Ibid

8. Ministry of Health, Maternity Report, 2005.

9. Health Services Consumer Research, Maternity Services Consumer Survey Report, Auckland, 10 January 2008.

Vision

The vision for maternity services is:

Women will experience pregnancy and motherhood as normal life events with confidence in their ability to give birth.

Women¹⁰ will have the information they need to make confident and informed decisions about pregnancy and birthing, and live and work in an environment that enables and supports their decisions. Women will have access to support to help them gain confidence in their ability to give birth and pass on that knowledge to family, friends, and successive generations. Communities, along with health and social services, will provide accessible, consistent and knowledgeable support to women who need it.

Women will easily access a Lead Maternity Carer who will provide their continuity of maternity care no matter where they live. They will also be able to easily access secondary and tertiary services should they need it.

Within a society that values, protects, promotes and supports birth as a normal life event, normal birth¹¹ and maternal and infant outcomes will be reflected positively in the data. These rates will also show a significant improvement across all population groups, and there will no longer be any significant differences between the birthing outcomes of different ethnic, socioeconomic or geographic communities.

There will be accessible and appropriate birthing and parenting information, education and support services for all eligible women, fathers/partners, families and whānau from all cultural and ethnic groups, and for migrant communities, low income families and young mothers.

Government planning, policy and service delivery decisions will be considered with a view to actively protecting, promoting and supporting maternity services. This occurs across all relevant government agencies in ways that fully involve and respond to communities.

10. The Maternity Action Plan recognises that it is women who experience pregnancy, birth and the postpartum period. Every woman also lives in a social environment that includes her baby, partner and family/whānau. The use of the words woman/women throughout this document is inclusive of babies, partners and family/whānau.

11. WHO definition: normal birth is described as: spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition. <https://www.who.org/reproductive-health/publications/>

Principles

1. Maternity services ensure a woman-centred approach.
2. Maternity services are delivered in a way that acknowledges pregnancy and childbirth as a normal life stage.
3. Maternity services are aimed at improving health outcomes and reducing inequalities.
4. Maternity services provide safe, high quality services that are nationally consistent and continuously improve.
5. All women have access to a comprehensive range of maternity services that are funded and provided appropriately to ensure that there are no financial barriers to access for eligible women.
6. Maternity services are culturally safe and appropriate.
7. Maternity service providers work together in partnership with women to ensure a seamless process throughout the continuum of maternity care.
8. Maternity services are equitably and appropriately funded for the provision of an effective range of maternity services.

Principle 1

Maternity services ensure a woman-centred approach.

The principle recognises that maternity services are centred on the woman and designed to meet her specific needs. All women should have continuity of care throughout the pregnancy, labour and birth and the postnatal period supported by a Lead Maternity Carer. Women, their partners and whānau should have good quality information enabling them to make informed decisions at different stages of their childbirth experience. They should feel supported and assisted towards the best possible outcome including entering parenthood with confidence.

Principle 2

Maternity services are delivered in a way that acknowledges pregnancy and childbirth as a normal life stage.

This principle recognises that pregnancy and childbirth are a normal life stage for most women as part of their lifespan. It acknowledges childbearing as a life event in which the importance of informed consent and decision making for parents is supported and respected. It recognises the importance of providing women with the encouragement and support to give birth without intervention. It also recognises the importance of ensuring the mother with health issues and/or who require medical or obstetric interventions experiences birth positively.

Principle 3

Maternity services are aimed at improving health outcomes and reducing inequalities.

This principle recognises that a population approach to planning and providing maternity services is necessary to identify high need groups. It is important that maternity resources are targeted to ensure the availability of responsive and appropriate services for Māori and Pacific peoples to reduce inequalities and improve outcomes. Maternity services need to be constantly responsive and adapt to ongoing changing needs in the community.

Principle 4

Maternity services will provide safe, high quality services that are nationally consistent and continuously improve.

This principle recognises that the quality and safety of maternity services is important in New Zealand and is central to maintaining public confidence in maternity services. It recognises the need for evidence-based national standards for maternity care.

The principle also recognises that good information systems are necessary for the effective monitoring and evaluation of maternity services.

Principle 5

All women have access to a comprehensive range of maternity services that are funded and provided appropriately to ensure that there are no financial barriers to access for eligible women.

This principle recognises that all women should have timely access to maternity services no matter where they live in New Zealand including access to a skilled maternity workforce.

This principle also recognises that there are a number of barriers to access for different groups of women including Māori and Pacific women, women living in rural communities, women with mental health disorders and women with disabilities¹².

To achieve this principle there needs to be systems in place to ensure that women from rural and provincial areas have access to similar maternity services as women from the main city areas. This includes access to tertiary services including acute obstetric care and neonatal units.

Maternity services also need to be funded and provided appropriately to ensure that there are no financial barriers to access for eligible women.

Principle 6

Maternity services are culturally safe and appropriate.

This principle recognises that maternity services should be delivered in a culturally safe way to people from the variety of different cultures within New Zealand.

Among Māori, *te whare tangata*¹³ acknowledges the special, particular role of women as the guardians and bearers of past, present and future generations. *Te whare tangata* encapsulates the mana and dignity of women; their womb is the house of humanity. From menarche (puberty) to menopause there is a continuum of knowledge that defines womanhood. Pregnancy and childbirth are rites of passage, which determine personal and collective identity, status, resilience and wellbeing.

In line with *He Korowai Oranga*, services to Māori will be provided in a way that improves Māori health outcomes and reduces Māori health inequalities. This should be achieved by facilitating Māori access to maternity services, ensuring appropriate pathways through those services, and addressing the primary maternity needs of Māori. Outcome measures for maternity services should include those endpoints that are valued by Māori.

For women of all cultures, this principle acknowledges the right to live in a society that nourishes and protects the inter-generational transmission of birthing rituals and knowledge. Such knowledge belongs, inherently, to women and their *whānau* but maternity professionals must also have the skills to ensure their service is culturally safe and

appropriate. Maternity professionals should also understand the importance of traditional

12. Ministry of Health and Child Youth and Family, *Improve Support to Parents with Disabilities* May 2008.

13. The reproductive functions of women.

birthing practices within different cultures.

Principle 7

Maternity service providers will work together in partnership with women to ensure a seamless process throughout the continuum of maternity care.

This principle recognises that the relationship between the woman and the maternity practitioner is one of partnership. Informed choice and consent is central to an effective partnership, along with shared responsibility and empowerment of women.

The principle recognises that all women will have a midwife to attend them and some women will also have a doctor. The provision of maternity services requires effective integration of maternity providers across community, hospital and regional services. It requires midwives, medical and other health professionals to communicate and collaborate in a team approach to ensure that women receive safe, quality care throughout pregnancy.

It also requires maternity providers and services to have effective linkages with primary care, well child and paediatric services.

Principle 8

Maternity services are equitably and appropriately funded for the provision of an effective range of maternity services.

This principle recognises that it is important to fund cost-effective maternity services using funding mechanisms based on sound financial principles. These include the use of suitable data to demonstrate cost-effectiveness of maternity services.

The principle also recognises that funding mechanisms can have an effect on how well maternity services are experienced and provided and that this should be taken into consideration in the planning and provision of maternity services.

Current Issues in Maternity Services

Leadership

The government has a leadership role in creating policy, regulation and legislation that promotes and supports maternity service provision to its population. District Health Boards as part of government are responsible for the health of their population and the provision of quality maternity services. While there is some evidence of leadership in New Zealand there needs to be more consistent national, regional and local leadership in maternity policy and services.

Provision, integration and co-ordination of maternity care

It is essential that maternity services be provided to meet the needs of New Zealand women. This requires access to the full range of maternity services including lead maternity carers (LMCs), secondary and tertiary maternity services. To ensure that women receive appropriate maternity care, services need to be accessible, co-ordinated and integrated. Currently some women have difficulties accessing maternity services particularly in rural and provincial areas. In addition, full co-ordination and integration of primary, secondary, tertiary maternity services, primary care and other related government and health services has yet to be achieved.

Quality and safety

The quality and safety of health services is important in New Zealand and is a focus of health services internationally. Cultural safety and appropriateness of maternity services is also important. There have been some quality assurance activities at different levels of the maternity sector eg, national information systems, professional standards, quality of individual DHB maternity services. There is a lack of a nationally co-ordinated focus on quality improvement within the maternity sector and this needs to be developed eg, the development of national standards, performance and clinical indicators.

Maternity information systems and data collection

Efficient and effective information systems are needed to provide good data to monitor the performance of the maternity sector and to assist in providing direction for quality improvement activities. There is evidence that the current data collection is neither complete nor accurate enough to support monitoring requirements on the quality or safety of services being delivered. A modern integrated information system is urgently needed to capture data at the point of service, including clear data definitions, data structure, communication protocols and privacy protocols.

Inequalities

In New Zealand there are differences in health status related to socioeconomic status, ethnicity, gender and where people live. Differences in access to health care services have a considerable impact on people's health status and mortality and are particularly relevant when it comes to providing maternity services. It is important that all women and babies have equal opportunity to have optimal maternity outcomes. There is evidence that some groups of women are disadvantaged with respect to access and/or outcomes:

- Māori and Pacific women

- women from rural communities
- women with disabilities
- women with mental health disorders
- women with drug and alcohol abuse issues
- migrant and refugee women.

Actions to address health inequalities should tackle social and economic inequalities as well as improving access to and effectiveness of health and disability services. Various tools have been developed to provide assistance in developing interventions with an equity focus. The Ministry of Health commonly uses the Reducing Inequalities Intervention Framework¹⁴ and the Health Equity Assessment Tool¹⁵.

Workforce

A sustainable maternity workforce is required to ensure that all women have access to an LMC and specialist assistance when required. Currently there is a national shortage and maldistribution of midwives and obstetricians. This is particularly an issue for rural and provincial areas.

There is a growing reliance on overseas trained midwives and obstetricians that is not sustainable over time. There are a multiple reasons for the workforce shortages, eg, an aging workforce, insufficient numbers being trained and difficulties in recruitment and retention. Workforce shortages lead to higher workloads and work related stress making the current LMC model of care vulnerable.

In addition to the shortage of midwives and obstetricians the numbers of GPs who are undertaking the Diploma of Obstetrics is minimal. This has led to a concern that GPs will eventually not have sufficient knowledge and expertise in women's health and early pregnancy.

Relationships and multidisciplinary co-operation

Relationships between providers, maternity services, professional groups, DHB funding and planning and Ministry of Health are currently not functioning optimally. This is partly due to lack of:

- national leadership
- integration and co-ordination of maternity services
- integration of primary, secondary and tertiary service specifications
- a common understanding of the referral guidelines
- clarity around roles and responsibilities.

Workforce shortages further exacerbate relationship and communication difficulties.

14. Ministry of Health, Reducing Inequalities Intervention Framework, 2002.

15. Te Ropu Rangahau Hauora a Eru Pomare et al 2003.

Priorities, Goals and Actions

The Maternity Action Plan proposes goals and actions that describe what needs to be done. The challenge for agencies, groups and communities is to work collaboratively to support maternity services in New Zealand. The goals and short, medium and long-term actions are outlined in the following tables.

The timeframes for the Plan are:

Short-term actions:	2008–2010
Medium-term actions:	2010–2012
Long-term actions:	2012 onwards

Leadership

Responsibility: Ministry of Health, DHBs, primary health organisations, professional colleges

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 1: To provide national leadership to the maternity sector to ensure that national maternity policy is developed and implemented.</p>	<p>Ministry of Health to provide national leadership in maternity services for the implementation of the Maternity Action Plan.</p> <p>Ministry of Health to establish a steering group that oversees the implementation of the Maternity Action Plan.</p> <p>RANZCOG and NZCOM and other professional colleges provide leadership to collectively address maternity issues and provide advice to the Ministry of Health.</p>	<p>Ministry of Health in partnership with DHBs, professional colleges and consumers review and update the Maternity Action Plan.</p>	<p>Ministry of Health continues to work in partnership with DHBs, professional colleges and consumers to review the effectiveness of the Maternity Action Plan.</p>

Provision, co-ordination and integration of maternity services

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 2:</p> <p>To monitor and further develop maternity services to provide:</p> <ul style="list-style-type: none"> • a seamless, integrated service for women and their babies • mechanisms for the effective co-ordination and collaboration of all maternity providers, primary care and other relevant providers • consistent and well understood service specifications and DHB accountability arrangements. 	<p>Ministry of Health in partnership with the DHBs professional colleges and consumers to further develop, integrate and implement the service specifications for primary, secondary and tertiary maternity services.</p> <p>Ministry of Health in partnership with DHBs to:</p> <ul style="list-style-type: none"> • develop effective linkages with primary care and other relevant government programmes • investigate models of primary care integration currently working effectively. 	<p>Ministry of Health in partnership with the DHBs, professional colleges and consumers to review and report on progress and achievements on the implementation of the updated service specifications.</p>	<p>Ministry of Health to evaluate the effectiveness of the service specifications and DHB accountability arrangements.</p> <p>Maternity services utilise consumer feedback in the development of services locally and nationally.</p> <p>Ministry of Health and DHBs monitor the funding of maternity services in line with the quality provision of maternity services.</p>
<p>Goal 3:</p> <p>To ensure that women and their babies have equitable access to a full range of maternity and other related services based on need.</p>	<p>DHBs to develop collaborative regional networks of maternity services that ensure women will have access to primary, secondary and tertiary services in line with best practice referral guidelines.</p> <p>Ministry of Health in partnership with the DHBs, professional colleges and consumers to update the referral guidelines for consultation with a specialist and the transfer of women between primary, secondary and tertiary services.</p>	<p>DHBs will provide access to the range of maternity care facilities and services based on need.</p> <p>LMCs are readily identifiable and active within DHBs and PHOs.</p> <p>All DHBs to promote and support continuity of care for women.</p> <p>Ministry of Health in conjunction with DHBs and professional colleges to develop a model of obstetric led care that ensures women receive continuity of care from the secondary/tertiary service</p>	<p>DHBs to review the effectiveness of access to maternity services through the regional network.</p> <p>DHBs to promote and support a seamless maternity journey for pregnant women and their babies regardless of their choice of birth facility.</p> <p>DHBs to have effective transfer systems in place to secondary and tertiary maternity care based on the updated referral guidelines.</p> <p>All DHBs to have effective contracts with</p>

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
	<p>DHBs to develop effective transfer systems to secondary and tertiary maternity care including having effective linkages with ambulance and air emergency transport services for emergency situations.</p> <p>Ministry of Health to work with DHBs to develop mechanisms for women to access LMCs and to monitor access.</p> <p>Ministry of Health to investigate funding mechanisms for access to primary health care services for women with co-morbidities in pregnancy.</p>	<p>similar to LMC led care.</p> <p>Mothers and families with complex needs to have access to free specialist consultant services that are co-ordinated and integrated with community based maternity care.</p> <p>PHOs to have effective early pregnancy information and LMC referral arrangements.</p> <p>All maternity services are linked to the Emergency Care and Co-ordination Network.</p>	<p>ambulance and air emergency transport services.</p>
<p>Goal 4:</p> <p>To encourage the development of innovative approaches to protect, promote and support normal birth.</p>	<p>Ministry of Health in partnership with DHBs and community providers to assess and scope capacity for primary maternity facilities.</p> <p>Ministry of Health to actively promote birth in primary facilities and at home.</p>	<p>DHBs to establish primary maternity facilities in which women can give birth.</p> <p>Ministry of Health to continue to actively promote birth in primary facilities and at home.</p>	<p>DHBs to regularly monitor women's experience and utilisation of primary maternity facilities and home birth.</p> <p>Ministry of Health to monitor and report on normal birth outcomes.</p>
<p>Goal 5:</p> <p>To increase access for all women and babies to preventative public health interventions that promote the health of women and their babies.</p>	<p>DHBs to ensure that women and babies have access to the full range of preventative public health interventions, eg, antenatal screening programmes, smoking cessation programmes, support for alcohol abstinence during pregnancy, support and assistance where there are family violence and immunisation programmes.</p> <p>All maternity services to implement the</p>	<p>DHBs and maternity services to provide joint public health programmes with primary care services and public health units for women and babies.</p> <p>All maternity services continue to implement the Breastfeeding Action Plan.</p>	<p>DHBs and maternity services to review the effectiveness of public health programmes for women and their babies.</p> <p>DHBs to monitor the success of the Breastfeeding Action Plan.</p>

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
	Breastfeeding Action Plan including gaining accreditation for the Baby Friendly Hospital and Community Initiative.		

Quality and Safety

Responsibility: Ministry of Health, DHBs, PHOs, professional colleges, consumer Organisations

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 6:</p> <p>To develop a national quality framework for New Zealand maternity services that aligns with service specifications and other accountability documents to ensure:</p> <ul style="list-style-type: none"> • access to a nationally consistent quality service • a culturally safe and appropriate maternity service • the continual improvement of maternity services • a set of national maternity standards • a set of key performance and clinical indicators. 	<p>Ministry of Health and DHBs in partnership with professional colleges and consumer organisations to develop a quality framework for maternity services in conjunction with the relevant professional colleges that aligns with service specifications and DHB accountability arrangements.</p> <p>Ministry of Health and DHBs in partnership with professional colleges and consumers develop a multidisciplinary clinical governance framework that includes:</p> <ul style="list-style-type: none"> • recognition of national services specifications and accountability documents • national service standards and performance indicators for maternity services that builds on current standards and quality indicators • a national set of clinical indicators. <p>Ministry of Health, DHBs in partnership with professional colleges, consumer organisations, Māori and Pacific organisations to develop a cultural competency framework for maternity</p>	<p>Ministry of Health to monitor maternity services using agreed performance indicators.</p> <p>Ministry of Health to update the evidence base for maternity services including the updating and development of new guidelines for maternity care.</p> <p>Ministry of Health in partnership with DHBs and professional colleges implement the multidisciplinary clinical governance framework.</p> <p>All DHBs to monitor the quality and effectiveness of their maternity services.</p> <p>Ministry of Health to develop a maternity research plan that informs the maternity services evidence base.</p>	<p>DHBs are benchmarked against performance and clinical indicators.</p> <p>Maternity services data to be used to inform the evidence based for the development of maternity services.</p> <p>Ministry of Health and DHBs in partnership with professional colleges and consumers review and adjust the multidisciplinary clinical governance framework.</p>

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
	<p>services.</p> <p>All DHBs and maternity services to have a quality improvement plan for maternity services that include a plan to improve cultural safety.</p>		
<p>Goal 7:</p> <p>To ensure that all women have access to information and education services to enable women to:</p> <ul style="list-style-type: none"> • give birth with confidence • develop the skills to give birth normally • have the best opportunity to achieve a satisfying birth experience • have effective preparation for pregnancy, birth and parenting • enable women to reclaim safe, traditional birthing practices • make informed choices throughout maternity care. 	<p>Ministry of Health and DHBs in partnership with professional colleges and consumer groups to review and update the pregnancy and parenting education specifications.</p> <p>DHB maternity services to initially target areas that have limited or no current childbirth education services.</p> <p>Ministry of Health, DHBs and LMCs to provide women with culturally appropriate information on maternity services available to them, in translation where needed.</p> <p>Ministry of Health in partnership with professional colleges and consumer organisations to develop culturally appropriate teaching and learning resources on the skills women need to give birth normally.</p>	<p>DHBs to provide childbirth education in all areas of New Zealand and to all population groups particularly high need groups.</p> <p>DHBs and maternity services to co-ordinate and effectively collaborate with other agencies that provide childbirth and parenting advice.</p> <p>The Ministry of Health links with Ministry of Education to support the inclusion of childbirth and parenting information into the Health and Physical Activity curriculum.</p> <p>The Ministry of Health to review and update the publication <i>Your Pregnancy</i> to provide more comprehensive information on maternity services, keeping pregnancy healthy, keeping birth normal, and postnatal support.</p>	<p>Ministry of Health and DHBs to review and report on the effectiveness of childbirth education including utilisation, geographical access, effectiveness, and availability to high need groups.</p> <p>Ministry of Health and DHBs to review the effect of teaching and learning resources.</p>

Maternity Information Systems and Data Collection

Responsibility: Ministry of Health and DHBs

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 8:</p> <p>To develop a modern integrated data collection system for maternity services at a local and national level that ensures data capture at point of service, that supports clinical intervention, local clinical governance, administration and service provision, strategy and policy development and quality research.</p>	<p>Ministry of Health to assist DHBs to work towards developing a set of standard data definitions for the national minimum data set.</p> <p>Ministry of Health to assist DHBs with development of way of safe electronic information sharing between maternity providers.</p> <p>Ministry of Health to re-establish a national maternal newborn information systems advisory group who report to the maternity steering group.</p> <p>Ministry of Health to institute systems for the routine monitoring and reporting on equity of access.</p>	<p>Ministry of Health to develop a standard set of electronic maternity notes that are applied nationally.</p> <p>Ministry of Health to develop a comprehensive national maternity information system that provides recent and timely comprehensive maternal and perinatal data that enables accurate monitoring of key performance indicators for maternity services nationally, regionally and by district.</p> <p>Ministry of Health to introduce a national perinatal epidemiology unit/resource that analyses maternity data, (from New Zealand Health Information Systems, Maternal Newborn Information Systems, Perinatal and Maternity Mortality Review Committee, Child and Youth Mortality Review Committee, National Immunisation Register, Accident Compensation Corporation, and Health and Disability Commissioner) monitors outcomes and supplies this information to DHBs.</p> <p>Ministry of Health to routinely collect and publish data by ethnicity for the monitoring of progress in reducing</p>	<p>Ministry of Health to integrate data sets so that quantitative and qualitative data can be analysed and produced for maternity services planning and monitoring.</p> <p>Ministry of Health and DHBs to use data and research to design monitor and evaluate maternity strategies, programmes and services at a national, regional and district level.</p>

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
		inequalities.	

Inequalities

Responsibility: Ministry of Health, DHBs, maternity services, LMCs

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 9: To identify and reduce inequalities in maternity outcomes.</p>	<p>Ministry of Health to analyse existing maternity outcome data to identify where the inequalities exist.</p> <p>Ministry of Health and DHBs to identify barriers to access for Māori and Pacific peoples and other high need groups.</p> <p>Ministry of Health and DHBs to investigate and provide solutions for disparities in access to maternity services.</p>	<p>Ministry of Health in partnership with DHBs and professional colleges to develop performance and clinical indicators to provide data on inequalities for national, regional and district networks.</p> <p>Ministry of Health, DHBs and maternity services to identify effective interventions for the reduction of inequalities in maternity services.</p> <p>DHBs and maternity services to apply the Health Inequalities Assessment Framework (HEAT) to the planning and provision of maternity services.</p>	<p>Ministry of Health in partnership with DHBs and professional colleges identify performance targets for reducing inequalities.</p> <p>Ministry of Health and DHBs to report on progress in reduction of inequalities.</p>

Maternity Workforce

Responsibility: Ministry of Health, DHB, maternity services, tertiary education providers, professional colleges

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 10: To develop a maternity workforce plan that builds on current national health workforce initiatives to ensure the availability of a skilled maternity workforce for New Zealand.</p>	<p>Ministry of Health, DHB Future Workforce Strategy Group, professional colleges, TEC, and the Medical and Midwifery Councils to develop and implement a maternity workforce strategy building on current work in relation to:</p> <ul style="list-style-type: none"> • forecasting, planning and supply • training more midwives and obstetricians • increasing numbers of Māori maternity providers • strategies for clinical placements • incentives to move the maternity workforce to areas where the shortages are eg, rural areas • support for immigration of overseas midwives and doctors • transparent accreditation, orientation and supervision/support for overseas obstetricians and midwives • encourage and support the uptake of the Diploma of Obstetrics • marketing midwifery and obstetrics as 	<p>DHBs and maternity service providers to have an agreed baseline maternity workforce capacity (eg, number of FTEs) established for each DHB including for sub-specialities.</p> <p>Ministry of Health and DHBNZ to use collected data to better utilise professionals within the maternity workforce.</p> <p>DHBs to ensure that the maternity workforce is configured to provide the cost effective service at the closest level to the woman's home by the most appropriate maternity provider.</p> <p>Ministry of Health and DHBs to provide maternity workforce placement and coverage for all DHBs in the region.</p> <p>Maternity service providers have effective recruitment and retention strategies for maternity workforce.</p> <p>DHBs to establish midwifery leadership positions for the co-ordination of maternity services in each region.</p>	<p>Ministry of Health and DHBs to have effective workforce planning systems in place that uses quality data to inform the development and monitoring of the maternity workforce.</p> <p>DHBs to have effective workforce programmes to ensure that all DHB areas have a sustainable maternity workforce.</p>

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
	<p>professions</p> <ul style="list-style-type: none"> • recruitment, retention, remuneration and employment conditions for maternity staff • training needs and distribution of sub-specialists <p>Ministry of Health to keep funding the Midwifery First Year of Practice programme for the retention of midwives</p> <p>Ministry of Health to fund post-graduate education for the midwifery workforce through the Central Training Agency (CTA).</p> <p>All DHBs and maternity services to:</p> <ul style="list-style-type: none"> • identify the workforce requirements of their maternity workforce • identify innovative ways to support maternity service provision while health workforce shortages exist • maintain the current LMC concept of continuity of care with responsive acute obstetric service backup • increase the number of Māori in the maternity workforce. 	<p>DHBs work with professional colleges to provide upskilling processes for the maternity and health workforce in rural and provincial areas where obstetric and gynaecology expertise is not locally available.</p>	

Relationships and Multidisciplinary Co-operation

Responsibility: Ministry of Health, DHBs, primary health organisations, professional colleges, maternity providers and LMCs

Goal	Short-term Actions 2008–2010	Medium-term Actions 2010–2012	Long-term Actions 2012 onwards
<p>Goal 11: To develop more effective relationships between providers, funders and professional groups to ensure effective communication and collaboration in the provision of maternity services.</p>	<p>Ministry of Health to organise national multidisciplinary forums for presenting and sharing innovative maternity practice.</p> <p>DHBs to organise local multidisciplinary forums for the presenting and sharing of innovative maternity practice.</p> <p>As part of developing a maternity services network, Ministry of Health, DHBs and PHOs to develop mechanisms for more effective working relationships between general practice, Well Child service providers, paediatric services and LMCs.</p>	<p>Ministry of Health and DHBs to have organised systems for communicating innovative multidisciplinary maternity practice.</p>	<p>DHBs to share and adopt innovative maternity programmes from other DHBs.</p> <p>DHBs to regularly review and develop maternity services in a collaborative manner.</p>

Appendix 1: The Maternity Action Plan in Context

This section describes the wider strategic context for the Maternity Action Plan.

The New Zealand Health Strategy (2000)

The New Zealand Health Strategy provides an overall framework for the health sector, with the aim of directing health services at those areas that will ensure the greatest benefit for our population and reducing inequalities of health.

Access to appropriate primary health care, maternity and public health services is an important part of the New Zealand Health Strategy.

The New Zealand Disability Strategy (2001)

The New Zealand Disability Strategy is aimed at eliminating the barriers to people with disabilities participating in and contributing to society.

The Strategy has the vision of a society that highly values the lives and continually enhances full participation of disabled people. The Maternity Action Plan recognises the rights of women with disabilities to the usual normal, quality experience of maternity services.

Primary Health Care Strategy (2001)

The Primary Health Care Strategy is the Government's main strategy for improving population health. The vision of the Primary Health Care Strategy is that all people will be part of local primary health care services (PHOs) that are aimed at improving population health through health promotion and preventative care. The strategy also seeks to reduce inequalities, develop the primary care workforce and improve quality of care.

The six key directions for primary health care are to:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas
- develop the primary care workforce
- continuously improve quality using good information.

In line with the Primary Health Care Strategy, the current Lead Maternity Carer model has a greater emphasis on health promotion, health prevention and home-based community care. In developing the future of maternity services there is a place for more effective integration of primary maternity services with primary health care services to ensure continuity of care across health services for pregnant women.

Sexual and Reproductive Health Strategy (2001)

The vision for the Sexual and Reproductive Health Strategy is 'good sexual and reproductive health for all New Zealanders'.

The focus of the strategy is on the increasing number of sexually transmitted diseases and the high level of unintended and unwanted pregnancies. The work of this strategy needs to be considered alongside the implementation of the Maternity Action Plan.

Child Health Strategy (1998) and the Well Child Framework (2002)

The overall vision for the Child Health Strategy is 'Our children/tamariki: seen, heard and getting what they need'. The strategy identifies four priority populations: tamariki Māori, Pacific children, children with high health needs and disability support needs, and children from families with multiple social and economic disadvantages.

All children need a good start in life to ensure the best possible potential for good health in their future life. It is therefore important that the Maternity Action Plan recognises the important influence of the maternity period in relation to child and future adult health.

He Korowai Oranga: Māori Health Strategy (2002)

He Korowai Oranga: Māori Health Strategy sets the Government's direction for leadership and decision-making about Māori health issues within the health and disability sector. The principles of Partnership, Participation and Protection underpin the relationship between the Government and Māori and are integral to the strategy. The Government is committed to improving Māori health and reducing Māori health inequalities.

He Korowai Oranga: Māori Health Strategy provides a framework and specific priority action areas to improve Māori health outcomes. It identifies four pathways that need to be addressed:

- Development of whānau, iwi and Māori communities including the recognition and values of Māori models of health and traditional healing.
- Māori participation in the health and disability sector at all levels.
- Effective health and disability services – timely, high quality, effective and culturally appropriate services to improve health and reduce inequalities.
- Intersectoral collaboration – with the health and disability sector taking a leadership role across government sectors and government agencies to achieve whānau ora by addressing the broader determinants of health.

This strategy is particularly relevant to the future direction of maternity services.

Pacific Health and Disability Action Plan (2002).

The Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. It is directed at the health and disability service sectors that include maternity services and Pacific communities.

Youth Health: A Guide to Action (2002)

This document sets out goals, objectives and specific actions aimed at improving the health of New Zealand's young people aged 12 to 24 years. It was developed to guide the health sector, and other sectors that have an impact on the wellbeing of young people.

Achieving Public Health for All People: Whakatutuki te Oranga Hauora Mo Nga Tangata Katoa (2003)

This plan is directed at both the public health services and other health services including the maternity service. The goals of the plan are to:

- improve the overall health status of the New Zealand population.
- improve the health status of Māori.
- reduce inequalities in health.

Youth Pregnancy and Parenting Action Plan (2008)

The Action Plan presents the cross-government plan to improve outcomes for young people who are pregnant or parenting, and the children of young parents. It consists of three sections along the continuum from positive sexual health and behaviour, through healthy pregnancies to being a good parent.

National Strategic Plan of Action for Breastfeeding 2008–2012 (Ministry of Health 2008)

Breastfeeding is important for the physical, social, emotional and mental health and wellbeing of infants, mothers and families. The breastfeeding action plan outlines strategies to promote protect and support breastfeeding. This plan is complementary to the Maternity Action Plan.

Other related programmes

Other related work led by the Ministry of Health includes work on:

- foetal alcohol syndrome prevention
- smoking cessation
- antenatal screening – Down's syndrome, HIV, newborn hearing
- family violence programmes
- initiatives to recruit and retain the rural midwifery workforce
- immunisation programmes.

Appendix 2: Members of the Maternity Services Strategic Advisory Group

Maternity Services Strategic Advisory Group

Name	Role/Organisation
Dr Anna Skinner	Rural GPO and Member of Royal New Zealand College of General Practitioners (until May 2008)
Frances Townsend	Policy Advisor RNZCGP from May 2008
Dr Elaine Langton	Specialist Anaesthetist, Clinical Leader Obstetric Anaesthesia Wellington Hospital
Estelle Mulligan	Practising Midwife, Chairperson Nga Maia o Aotearoa me Te Waipounamu
Jackie Gunn	Head of Midwifery, School of Midwifery, AUT University
Dr Gillian Gibson	Obstetrician & Gynaecologist, Chair of NZ Committee of Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Dr Mark Peterson	Rural GPO, Maternity spokesperson for New Zealand Medical Association – Board Member; Chairperson, GP Council
Mollie Wilson	Part-time CEO – Paediatric Society of New Zealand
Norma Campbell	Midwifery Advisor – New Zealand College of Midwives
Dr Rachael McEwing	Charge Radiologist, Christchurch Women's Hospital
Dr Stephanie Palmer	Consumer representative – Nga Maia o Aotearoa me Te Waipounamu
Siniva Cruickshank	Antenatal educator, Health Star Pacific
Sue Bree	President, New Zealand College of Midwives; Member – Midwifery Council of NZ
Dr Susan Fleming	Obstetrician & Gynaecologist, Clinical Director and Clinical Leader – Women's Health, Dunedin Hospital
Dr Celia Devenish	Obstetrician, Otago Medical School (May and June meetings 2008)
Karen Guilliland	Chief Executive Officer, New Zealand College of Midwives (from June 2008)
Trudi Ascroft	General Manager Childbirth Education, Parents Centre New Zealand Inc
Terryll Muir	Clinical Midwife Leader – Southland Hospital (to May 2008)

District Health Boards and Ministry of Health

Name	Organisation
Janice Donaldson	Portfolio Manager – District Health Boards New Zealand
Helene Carbonatto	General Manager Planning, Funding and Population Health, Tairāwhiti District Health Board
Sandra Boardman	General Manager Planning, Funding and Population Health, Taranaki District Health Board
Marilyn Rimmer	Manager – Workforce, District Health Boards New Zealand
Lyn Wardlaw	Maternity Services Manager – Northland District Health Board
Dr Pat Tuohy	Chief Advisor – Child and Youth Health, Ministry of Health
John Hobbs	Manager – Child, Youth and Maternity Policy, Ministry of Health
Julia Tinga	Senior Analyst – Child, Youth and Maternity Policy, Ministry of Health
Bronwen Pelvin	Senior Advisor, Maternity Services – Child, Youth and Maternity Policy, Ministry of Health
Jane Coster	Senior Advisor, Maternity Services and Contracts – Child, Youth and Maternity Policy, Ministry of Health

Appendix 3: Terms of Reference, MSSAG

Part I: Purpose of the Advisory Group

Maternity Services Project

The Ministry of Health, in partnership with DHBs, is undertaking a project to develop a strategic vision and implementation programme for maternity services in New Zealand.

The aims of this project are to:

1. develop a draft strategic vision for maternity services for the Ministry to consult on, and
2. prepare a draft action plan for consultation by 30 September 2008.

Role of the Advisory Group

A sector advisory group is being established to assist with this project. The advisory group is being co-sponsored by DHBs. It will have four general roles:

- to provide a variety of experience and views for the Ministry and DHBs to draw on
- to take a strategic view of maternity services across all parts of the maternity sector
- to assist with sector consultation on key issues
- to prepare for transition to an implementation phase.

Approach

The following approaches are suggested to guide the work of the group:

- environmental scanning to identify issues to be addressed
- using the 'woman's journey' approach and a quality improvement framework to identify issues
- reviewing New Zealand and overseas material in relation to the development of vision statements and principles
- identifying gaps between best evidence and current maternity service delivery
- reviewing the proposed outcomes/indicators for maternity services¹⁶
- developing criteria to assist prioritising for implementation
- preparing the plan for sector consultation
- preparing for transition to an implementation phase.

16. This will be in association with the working group Enhancing Maternal and Newborn Information Systems.

Scope

The scope of the work will take into account:

- primary-secondary interface issues, and the role of guideline review or development
- alignment with primary health care services
- impact of current funding arrangements
- current and future strategies to address workforce issues
- outcome/performance indicators
- quality assurance issues.

A fuller description of the scope of the project is set out in Appendix 1.

Funding issues may arise in the context of discussions, but will not be the focus of this work.

The project will not consider issues related to gynaecology, neonatal or paediatric specialty services, or well child services.

Longer term outcomes

The work of the group is expected to contribute to the following longer-term strategic objectives:

- improved maternal, infant and family outcomes
- reduced inequalities
- increased public confidence in the safety and quality of maternity services.

Context and linkages

Several maternity-related work streams are under way in the Ministry and through collective DHB activity that will be of interest to the project and the advisory group. These include:

- workforce planning and training
- antenatal screening
- enhancing Maternal and Newborn Information Systems
- review of well child services
- National Action Plan on Breastfeeding.

In addition, some external committees will also have an impact, including for example the Perinatal and Maternal Mortality Review Committee due to make its report by August 2008 or earlier.

Part 2: Terms of engagement

Membership of the group

A range of expertise and perspectives will be sought for the group, including:

- midwifery
- obstetrics
- general practice
- consumer representation
- diagnostic and screening services eg, radiology
- secondary/tertiary specialties (eg, paediatrics, anaesthetists)
- DHB funder and provider perspectives
- epidemiology/academic/teaching background

Some care has been taken to ensure the views of Māori and Pacific women are heard in the group, and that the special circumstances in rural areas can be considered.

Membership of the Strategic Advisory Group will be governed by the following guidelines:

- members will be appointed by the Ministry of Health
- the Ministry of Health will chair the Advisory Group, and may co-opt additional members if necessary to ensure appropriate coverage
- members are representing their area of expertise rather than an organisation
- members are expected to work collaboratively, with honesty and impartiality, and to act in the best interests of the maternity sector as a whole
- members are expected to declare any areas where they believe there is a potential conflict of interest
- proceedings of the meeting will be open and transparent, though confidentiality of particular issues can be requested through the Chair if necessary
- members are expected to use their judgement about discussing issues raised in the Advisory Group
- the vision and plan will belong to the Ministry of Health and will acknowledge the role of the Advisory Group
- the Chair of the group will act as the media spokesperson if required – members are able to speak as representatives of their own organisations, not as members of the Advisory Group.

Term of Appointment

The Strategic Advisory Group is expected to be in place for up to a year. Four meetings are likely to be held, with the group expected to review papers between meetings. Teleconference meetings or email correspondence may also be appropriate between full meetings. A decision on whether the group should continue to oversee implementation will be made after the first term.

Any member may resign by advising the Chair in writing. Where possible, this should be done well ahead of any scheduled meeting so that a replacement can be found and brought up to speed.

Fees and allowances

- Members of the Advisory Group (except DHB employees and organisations already contracted to provide advice), are entitled to fees for attendance at meetings. The level of attendance for fees is set in accordance with the Cabinet Office Fees Framework for Members of Statutory and Other Bodies appointed by the Crown.
- The attendance fee for the Maternity Advisory group is set at \$300 (excl GST) per day. This fee includes up to six hours' meeting time and four hours' preparation.
- Claims for expenses must be accompanied by receipts and tax code declarations.
- Locum fees will not be paid.
- Travel, and where applicable accommodation, will be provided for the member, provided this is booked via the Ministry of Health. Travel costs for DHB employees are at the DHBs expense.
- Where a member uses their personal vehicle to travel to Advisory Group meetings they are able to claim 62 cents per kilometre for distances travelled over 30 kilometres.

Secretariat support

The Ministry of Health will arrange secretariat support for the Advisory Group. This includes:

- assistance with travel and accommodation bookings
- preparation of agendas, reports and presentations for the Advisory Group. All material to be delivered at least four working days before Advisory Group meetings
- documentation of Advisory group discussions
- maintaining a register of risks or issues that need consideration by the Steering Group.

Steering Group

The Ministry of Health will convene a Steering Group to oversee the work of the Advisory Group. Its role will be to ensure a whole-of-Ministry view on the work of the group, to facilitate internal liaison, and to consider issues that fall outside the scope of the Advisory's group work but need to be addressed in some way. The DHB co-sponsor will also sit on the Steering Group.