Appendix two: Submission Form for the Review of the Maternity Referral Criteria and processes for the transfer of care (the Referral Guidelines)

Submissions close 5pm on **11 March 2011.**

Please detach and return to:
Sarah McDonald
Allen & Clarke Policy and Regulatory Specialists Ltd
PO Box 10 730
WELLINGTON 6143

An electronic version of this document and form are available. These can be requested and submitted to emailing smcdonald@allenandclarke.co.nz.

Submissions must be completed on this form, other formats of response will not be considered.

This submission was completed by:
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Are you submitting this as:

☐ an individual

☒ on behalf of a group or organisation

☐ other (please specify)

Purpose and principles (Page 10-11)

Question 1:

Are there changes, deletions or amendments to purpose or revision timeframe of the revised referral guidelines?

To strengthen links between ongoing engagement in primary health care, prior to and following the episode of pregnancy and psotpartum period.

Question 2:

Would you suggest any amendments to principles that should underpin the revised referral guidelines?

Documentation of the hand over of care must be clear, so that clinician repsonsibility is identified. this must also be verbally communicated

Levels of referral (Page 13)

Question 3: Do you agree with the proposed levels of referral? Please provide comments.

Yes

Question 4: Are the descriptions of consequent actions practical, appropriate and relevant to LMCs and appropriate for services receiving referrals?

Referral to another primary care provider P (Pages 15-17)

Question 5:

Do you think the process for referral to another primary care provider **(P)** conditions is practical? Please provide specific comments.

Generally yes, however there are regions around NZ where there are significant shortages of GPs where. There needs to be another mechanism by which babies are linked into well child immunisations etc and women are linked into appropriate primary health options within an appropriate timeframe when no GP is available. Currently some women who are not enrolled are taking their babies to Māori and iwi providers, who have a policy of not turning away anyone, for immunisation.

Question 6:

Are there the roles and responsibilities appropriate? Please comment.

Question 7:

In your area, could the process for **P** referrals be implemented at a general level? If not, why not? Please make suggestions for changes that would make the process more appropriate, bearing in mind the need for nationally consistent guidelines.

There is anecdotal evidence that in many areas, IT sytems do not interface well with each other, particularly between secondary / tertiary providers and primary health . Many LMCs do not have the IT infrastructure to link in to the wider client records sytems. The passing on of information between practitioners can be haphazard and would need to be addressed in a natioanlly consistent way so that information could be exchanged between regions/DHB .

Referral to a specialist for consultation C (Pages 18-20)

Question 8: Do you agree with the proposed referral process for conditions with a **C** referral level? Please provide detailed comments.

" Hand all notes to LMC". It would be sensible to have a copy kept by the GP if they were the iniital point of consult, as they will ultimately have the woman return to their care after the pregnacy and puerperium is over.

Question 9: Do you believe the roles and responsibilities outlined are appropriate? If not, why not? Please provide detailed comments and suggestions.

Agree with midwife communicating directly with the GP.

Question 10: Would the proposed process align with or provide a practical framework for your local circumstances? Please provide detailed comments.

Effective communication between the various disciplines providing care is ciritical for optimal maternal and infant outomes and ongoing engagement in care.

Transfer of care to a specialist T (Pages 21-23)

Question 11: Do you think the process for **T** level referrals is appropriate for the conditions listed in that category? Please provide detailed comment.

Question 12: Do you think the process will support clear allocation of roles and responsibilities?

There must be very clear transfer of responsibility of care. Issues that result in adverse outcome for mother or baby (including several cases investigated by the HDC) have had as a contributing factor a failure to effectively communicate that a transfer of care and therefore responsibility for decision making has occurred.

Question 13: Is this process applicable in your region? Would it support consistent practice? Please provide detailed comments.

Consistency is difficult to achieve when betwen DHBs there is not a consisitent process -this is more of an issue in large metropolitan areas where LMC may hold access agreements for several different DHB.

Emergency transfer E (Pages 24-26)

Question 14: Is the process outline for LMC response to obstetric emergencies appropriate for the conditions listed as **E** in the referral criteria?
Some conditions will not fully resolve postnatally (e.g.Brain injury due to hypoxia - either mother or baby) In such cases there must be appropriate referral for ongoing care which might not initially be from the GP.

Question 15: Does the process provide adequately for issues of clinical responsibility for care?
No. There needs to be tighter guidance around leadership in emergencies and acknowledgement that, in these cases, the LMC may not be the most appropriate lead and would need to recognise this.

Question 16: Would this process provide a useful framework in your region? Please provide comments to support your answer.
It is essential to recognise that there are two individual lives in the antental and intrapartum period - i.e. that the woman needs to be fully informed about the impact on her decision making on the infant.

Emergency Transport (Page 27-28)

Question 17: Is a standard emergency transport process useful to you? Please explain your answer.
In an obstetric emergency there should always be access to oxygen. If there is likelhood of delivery in transit, there must be personnel with adequate training and equipment to deal with this.

Question 18: Are there any issues in your area which would be a barrier to the operation of this process? Please provide details.
Lack of understanding and education for ambulance crew about risks to newborn when there has been an emergency with mother eg ante partum haemorrhage. Must be a clear process with the receiving unit as to where mother (& newborn) are to be received - i.e. birthing suite or emergency care department.

Question 19: Are there any other issues concerning emergency transport that you think should be considered in the development of a nationally consistent process for transport in obstetric emergencies? If so, please provide details.
This guideline refers only to road transport. There are specific considerations that pertain to air transport (fixed wing or helicopter). This should be included in regard to interhosptial transfers from primary/ secondary to teriary in particular. Consent may need to be obtained from next of kin if the woman is unable to consent for herself or her newborn infant .

Timing of referral (Page 29)

Question 20: Timely referrals are important to improving maternity outcomes. Do you have any specific comments regarding timely referrals as part of the process maps that follow? Please

provide comments to support your suggestions and clearly indicate which process you are referring to with regard to timely referrals.
Guidance must be clear, particualry for new practitioners. Local DHB policies should be supported by natioanlly recognised and consistent guidelines.

When a woman declines (Pages 30-31)
Question 21: Do you think it would be useful to include such guidance in the revised referral guidelines? Please give your reasons.
Documentation must be clear in regard to discussions that the practitioner has with the woman, partiularly in regard to informed choice and the woman's refusal against recommendation. Impact for her own health and that of the baby should be explained clearly.
Right to privacy can be respected whilst seeking the opinion of another colleague - this should not be used as an " out clause" to avoid having difficult discussions, especially where there is risk to the woman and her baby.

Question 22: Do you think the general points of processes when a woman does not consent are adequate and appropriate? Please provide comments.

Question 23: Are there any other issues, situations or matters which should be covered by a guide on processes when a woman does not consent? Please provide detailed suggestions.
The information does not refer to mental health issues - this should be included as a specific circumstance when the woman may not have the capacity to make decisions and their safety needs to be protected.

Implementation (Pages 32-35)
Question 24: What issues are you aware of that could influence the way the revised guidelines are implemented and used?
Geography, workforce and accessibility of services will need to be more fully addressed

Question 25: What suggestions do you have for approached to implementation that would address these issues?
A robust plan for action on the points/ barriers identified. Work locally and regionally - link nationally.

Question 26: What suggestions do you have for implementing the revised referral guidelines? Please consider dissemination; introduction/training in their use; ongoing support for the awareness and use of the referral guidelines.
Inclusion of Tertiary service providers in discussion

Question 27: Do you have any comments on monitoring and evaluating the revised referral guidelines? Please consider potential monitoring and evaluation criteria, priority questions, how information/results can be used, and limitations.

Revised Criteria (Appendix 1)

Question 28: Are there any conditions which you feel should be included? Please provide details of the specific condition, the reason it should be included, and evidence to support your suggestion.
no specific comment re clinical issues

Question 29: Are there any conditions which you feel should not be included? Please clearly identify the condition(s), and provide evidence to support your suggestion.

Question 30: Do you have any other comments about specific conditions, descriptions or referral levels? If so, please clearly identify the condition(s) you wish to comment on, and provide evidence to support your comments.

Question 31: Any other comments or feedback?

Thank you for the opportunity to comment on this document.
NZNO has a midwifery membership of over 700 midwives, most of these employed in the DHB setting in core midwifery roles. NZNO is particularly interested in the linkages to primary care that are outlined in this paper and in processes for effective nationally consistent information sharing between provider that are the subject of another project.

Effective and equitable access to primary care are key to improvements in the nation's overall health and well being (NZNO Manifesto, 2011). Emphasis on engagement in primary care prior to pregnancy and the provision of effective referral during and after pregnancy for ongoing health service provision is essential, as is engagement in well women programmes such as cervical and breast screening. Engagement of infants in well child programmes including immunization are also critical to overall improvements in child health.

Currently there are gaps in facilitating engagement or re-engagement in primary health care following the birth of the baby, with inconsistencies of how information is fed back to the GP. It is pleasing to see that this is being addressed within the document.

NZNO supports effective referral and transfer of care arrangements that will promote optimal outcomes for pregnancy, that will have long term health benefits for both the woman and her baby and supports the development of guidelines that will facilitate this .

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