www.findyourmidwife.co.nz
launched!

The New Zealand College of Midwives (the College) has now officially launched the national website www.findyourmidwife.co.nz

The College developed this site to enable women to access comprehensive information about LMC midwives available in their area. Although between 60% to 70% of women see a GP early in pregnancy, there is frequently a time delay between this first contact and women actually registering with an LMC. GPs may not be aware of the range of midwives providing LMC services in their area, or may provide little guidance or information to support their choice. Similarly, DHB maternity services may be a first point of contact for women seeking care and up to date information about available LMC midwives is a valuable resource for these services too.

Health care providers are encouraged to include links to www.findyourmidwife.co.nz from their own websites. The College has produced a range of promotional materials to assist providers to promote the site to women as well as informing them about how to use the site.

Early pregnancy is an opportune time for women to address health and lifestyle behaviours (such as smoking, alcohol and nutrition) in order to support a healthy pregnancy. The Perinatal and Maternal Mortality Review Committee (PMMRC) also recommends that women register with an LMC by 10 weeks gestation.

www.findyourmidwife.co.nz removes some of the barriers for women to access midwives by offering up to date online information.

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The site provides:

- A due date calculator for women who do not know when their baby is due
- A comprehensive list of LMC midwives which can be searched by relevant region, sub region or locality using a specially designed filter
- Midwives’ contact details including phone number and email
- Information provided by the midwives about themselves and their practice including a photograph and a link to the midwife’s website if she has one
- Regularly (monthly) updated midwife availability so women can tell at a glance which midwives are available to provide care to them based on their due date
- A “print list” option so women without access to a computer can have a printed copy of available midwives given by a service provider they have visited for first trimester care
- Links to practice partners Find Your Midwife profile for women to click through to view information about other midwives who may be involved in her care

Interface between primary maternity services, Well Child and GP services.

The interface between primary care services and maternity occurs at both ends of the maternity services continuum, at entry to maternity services and at exit or discharge. It is estimated that between 60% and 68% of women see a GP early in pregnancy.\(^2,3\)

Under the Primary Maternity Services Notice (Section 88) GPs are required to “provide written information including screening test results and relevant health information to the woman and her LMC on care provided”. Unfortunately the frequency with which this occurs is not recorded nor does it seem to happen often, as the GP may not know who the LMC is going to be at the initial early pregnancy visit (www.findyourmidwife.co.nz can provide a means to assist here). This can be alleviated if the GP provides a copy of the relevant information to the woman herself, including noting what tests have been ordered. It may be useful to request copies of test results also be sent to the woman so that she can pass copies to the LMC when she registers for maternity care.

Section 88 requires LMCs to record referral of the woman and her baby to primary care and Well Child Tamariki Ora services. The figure below (taken from the 2010 Ministry of Health Report on Maternity) shows the percentage of women registered with an LMC that were referred to a GP and for whom a referral was made to Well Child Tamariki Ora on discharge from maternity care. The majority of women (and their babies) were referred to their GPs at discharge (91.5%), and a referral was made to Well Child Tamariki Ora in 92.5% of cases.

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2 Improving quality and safety in maternity services: can we improve prevention, detection and management of congenital abnormalities in pregnancy?: Health Quality & Safety Commission New Zealand; 2013

Implementing the Maternity Quality and Safety programme in Northland DHB

Michelle Bailey, midwife has been in the role of Northland DHB Maternity Quality and Safety Programme (MQSP) facilitator as 0.8FTE for a year now. Michelle is also co-chair of the NZCOM Northland region.

Each DHB is unique and its population needs, service configuration and outcomes will determine priorities for the MQSP. There are around 2,000 births in the Northland DHB region each year. Over 50% of these births are to Maori women, with the majority of women giving birth in quintile 4 and 5 (most deprived quintiles). The DHB covers a large rural geographic area, has one secondary unit based in Whangarei and 3 primary maternity units (Kaitaia, Bay of Islands and Dargaville (which is currently closed for intrapartum care due to midwifery workforce shortages).

Michelle has been leading the implementation of the MQSP in her role since her appointment 12 months ago and has achieved a huge amount within this time.

Setting up a multi disciplinary clinical governance group to provide oversight and guidance was a first important step taken by the DHB. This had been tried before but fell over due to lack of commitment. This is the first time a commitment has been made to LMCs, GPs and consumers to have their time paid for. The Associate Director of Midwifery is the chair of the group. This group includes representation from paediatrics, obstetrics, midwifery (DHB leadership), LMC midwifery, GP, consumer and Maori. One of the first actions of the group was to address access to LMC midwives for Northland women. Analysis from DHB data demonstrated that nearly 4% of Northland women were booking for maternity care after 36 weeks. Michelle initiated a survey for women to better understand what some of the barriers to accessing care were and the results revealed that 25% of respondents did not have access to the internet. It was assumed the internet would be used more. In light of this information, it was clear that women needed access to information about midwives and maternity care in a variety of forms. Michelle has overseen the development of a poster for women which includes an 0800 number for women linking them to their local primary maternity unit (as a source for further information about how to access LMC care) as well as information about the College’s ‘Find Your Midwife website’.

Other MQSP work which has been prioritised includes reviewing the policy for induction of labour (to ensure that processes surrounding induction are meeting the needs of women as well as clinicians, with reference to the rural nature of the population), developing a clinical risk management programme which has involved identifying 33 triggers to initiate case reviews, as well as projects to improve; knowledge and practice on fetal surveillance, handover of care processes as well as updating clinical policies and guidelines.

The framework of the MQSP has enabled the Northland DHB MQSP team to prioritise actions and projects which are relevant to the needs of its birthing population, as well as supporting practitioners to continuously improve the quality of maternity services.
Primary practitioners (LMC midwives) work alongside their facility based colleagues to provide care to women with additional needs through consultation, referral and transfer processes. The interface between primary and secondary services requires an understanding of each other’s roles as well as trust and respect between individual practitioners and services.

When a woman’s condition is becoming more complex, we often refer to the various frameworks that support New Zealand maternity services (such as the Section 88 Notice, the Referral Guidelines and the Facility Service Specifications) to assist us to determine respective roles and responsibilities. These documents are intended to guide practitioners in identifying what care the woman might require and at which point along the continuum. They are not intended to provide a literal interpretation of which practitioner is supposed to provide which care at which time. This should be determined by the context in which the care is provided including:

- the condition / needs of woman
- the experience of practitioners involved in the woman’s care
- the length of time the LMC may have been with the woman prior to seeking a consultation
- the geographic setting in which the care is being provided
- the immediate resources / staff available in the DHB service

Literal interpretations of the maternity service frameworks can be unhelpful as this approach may require LMCs to continue providing care when it may not be in the best interests of the woman for them to do so. Or it may require an LMC to cease being involved in care when, with the right support, the LMC may be the best midwife for that woman at that point in time. At times DHB staffing capacity may limit the amount of support that LMCs receive, or mean that LMCs are unable to handover care when that would be the best outcome for the woman. Midwifery staffing in DHB maternity units may simply be inadequate for the complexity of the needs of women and the services that DHBs are required to provide. If this is the case, task shifting to the LMC primary maternity workforce is not the right response. Instead, DHBs need to consider their FTEs, the needs of their population and how they can staff their unit to provide the required services.

When negotiating roles and responsibilities at the interface in these sometimes challenging situations, instead of asking, “what does Section 88 / Referral Guidelines / Facility Specifications say (about what should happen here)” should we instead be asking “what is in the best interests of the woman in this situation?”. From this question a number of others arise for DHB services.

- What do we do to enable LMCs who access this facility to continue to be involved in the care provision of women with more complex needs?
- Do we offer regular breaks, collegial support, as well as learning opportunities for newer practitioners who may need additional support?
- Do we seek feedback from LMCs about how they perceive the environment and support that is provided in this DHB?
- Do we treat LMCs as part of “the team” when we are working together to provide care to women who are using our facility?
• Do we have the correct number of FTEs in our maternity unit to enable adequate support to be provided to LMC midwives or to enable handover of care to occur when it needs to?

• What is the rate of transfer / handover of care for women being cared for in this DHB? Is this similar to other DHBs with similar populations?

LMCs may ask themselves:

• Do I ask DHB staff for the help that I need in a timely way and make my support needs clear?

• Do I ensure that my documentation is clear, concise and up to date so anyone else reading it will easily understand what is happening for this woman at this point in time?

• Do I work at relationships with my DHB colleagues and address issues that may arise in a professionally respectful way?

• Do I help out as I am able to assist my DHB colleagues when they are clearly stretched and having a busy day?

• What is the rate of handover / transfer for my caseload? Is this similar to my LMC colleagues?

Although it is important to understand the frameworks that support New Zealand maternity services, the documents should not be used to define what should happen in any given situation. Instead;

• the right balance of the right workforce (including skill mix and sufficient numbers of community and facility based practitioners)

• a shared understanding of each others roles, responsibilities and contexts for practice

• trust and respect between individual practitioners and services

• systems and processes which support communication, and information sharing will ultimately enable us all to keep the woman and her baby at the centre of care.

Norma Campbell and Karen Guilliland will be visiting the regions in the coming months to give midwives the opportunity to discuss their concerns around handover processes.