SUBMISSION
TO THE MINISTRY OF HEALTH

on the

Discussion Document: Proposed amendments to the Maternity Referral Guidelines and processes for the transfer of care

by

AIM
(ACTION TO IMPROVE MATERNITY)

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Contact Person: Tracy Abbott
Principal Advisor
The Versant Group
8 Oban Crescent
Wadestown
Wellington 6012
Phone: (04) 938 9544
Cell: 027 235 5177
Email: tracyabbott@clear.net.nz

I. AIM is a network of families and professionals seeking improvements in New Zealand's maternity system. This submission is made on behalf of AIM to provide feedback to the Ministry of Health on the Discussion Document: Proposed amendments to the Maternity Referral Guidelines and processes for the transfer of care ("the Discussion Document").

II. AIM is able to provide the following comment within the terms of reference as a group representing or associated with affected families, children and health care professionals. In developing this submission AIM's members were consulted and asked for their input, although individual members may also make their own submissions specific to their personal views.

III. At Appendix Two, information regarding this submission form states, "*Submissions must be completed on this form, other formats of response will not be considered.*" Please advise us whether or not the Ministry of Health gave authority for such a restriction.

IV. The terms of reference set out in this submission form are delimited by the poor quality of the questions and the insistence on a chronological as opposed to a contextual prioritisation. The priority given to any issue identified by a submitter should be theirs to determine and express accordingly. The limitations of the submission form do not serve the Purpose set out at 1.1 on page 5 of the Discussion Document, nor do they serve good communications generally. Notwithstanding this, AIM's submissions remain within the confines of the submission form.

V. We understand that the Expert Working Group that is reviewing the proposed amendments to the Maternity Referral Guidelines and processes for the transfer of care consists of:

1. Midwifery Advisor, New Zealand College of Midwives representative
2. CEO, New Zealand College of Midwives representative
3. Midwife, Graduate School of Nursing – Midwifery & Health
4. Midwifery Leader, Waikato DHB
5. LMC Midwife Waikato
6. LMC Midwife Northland
7. Maternity Services Consumer Council
8. Obstetrician, Auckland, RANZCOG representative
9. Specialist Anaesthetist, Clinical Leader Obstetric Anaesthesia – Wellington Hospital, NZSA rep
10. GPO, Taradale Medical Centre, RNZCGP representative
11. Chief Executive Officer, Paediatric Society of New Zealand representative
12. Medical Director, St Johns representative
13. CEO, Parents Centre New Zealand

We have been advised by Allen & Clarke Policy and Regulatory Specialists Ltd that the Parents Centre is representing consumer interests on the Expert Working Group. We wish to draw attention to the fact that the CEO, Parents Centre New Zealand is also currently CEO of the Midwifery Council and is their Registrar. She is a former Deputy Chair of the Midwifery

Council and is the current Chair of the Midwifery Council Professional Conduct Committee. We have been advised that the Maternity Services Consumer Council is also representing consumer interests. The person representing the Maternity Services Consumer Council on the Expert Working Group is a midwife educator. On that basis, a majority of the members of the Expert Working Group are midwives or are associated with midwifery organisations. The balance of the Expert Working Group membership consists of health professionals. There does not appear to be any adequate or un-conflicted consumer representation.

Furthermore, the Expert Working Group's facilitator co-authored the 1986 foundation policy document on which the 1990 maternity reforms were developed. He is facilitating the working group that is reviewing his work.

We submit that there are apparent conflicts between the purpose of the review and the interests of a majority of the members of the Expert Working Group, as well as its facilitator. This presents a potential for the appearance of bias.

Question 1:
Are there changes, deletions or amendments to purpose or revision timeframe of the revised referral guidelines?

VI. AIM is concerned that the Revised Referral Guidelines are merely guidelines. We are of the view that Revised Referral Guidelines should contain minimum standards with legal effect. By way of comparison, New Zealand's Animal Codes of Welfare contain recommendations, guidelines and minimum standards. The minimum standards are deemed to be regulations, meaning that while a breach of a minimum standard in a code is not an offence, failure to adhere to such minimum standards may be used as evidence to support a prosecution, while compliance may be a defence. We submit that the Revised Referral Guidelines should be elevated to the status of a code, and amended to contain minimum standards with legal effect.

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.

VII. Many of the conditions set out at Appendix One are outside the scope of minimum training required for LMCs. With reference to the process maps set out at pages 15, 18 and 21 we submit that a condition should not be left to deteriorate before the process is progressed. If a condition persists, then that should be enough to trigger referral. By way of example, it might be difficult, and perhaps inappropriate for an LMC, with the minimum required experience and training, to determine whether or not a condition such as *1008 cardiac valve disease – mitral/aortic regurgitation* was deteriorating.

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.

VIII. With reference to:

a. *5018 meconium liquor, moderate or thick*, we submit that the presence of meconium liquor, be up graded to category E. We also submit that the condition be amended to read "meconium or any abnormal discoloration" and that the words "moderate or thick" be deleted. We understand that there is a divergence of clinical opinion regarding the significance of meconium in amniotic fluid. On this basis, we are of the view that a precautionary approach be taken.

b. *8011 severe infant depression at birth, e.g. Apgar score of 6 or less at 5 minutes with little improvement by 10 minutes*, we are not of the view that an LMC should wait 10 minutes before referral. We submit that referral should be immediate in those circumstances and that the condition, and, its description be amended accordingly and upgraded to category E.

c. *6003 post partum haemorrhage (PPH) > 600 mls with ongoing bleeding*, we submit that this constitutes an emergency situation and should be upgraded to category E. The reasons for this are self evident.

d. the un-numbered and un-described condition at page 49 of the Discussion Document, *Birth Injury*, we submit that if an infant has been injured this requires the urgent attention of a paediatrician. On that basis, it should be upgraded to category E.

e. *8054 Apnoea*, we submit that if an infant is not breathing, or not breathing normally, this constitutes an emergency situation and should be upgraded to category E.

f. *8056 Stridor, nasal obstruction, or respiratory symptoms not specified elsewhere,* we submit that along with *8054 Apnoea*, any significant respiratory distress should be treated as an emergency and upgraded to category E.

Question 31: Any other comments or feedback?

IX. We understand that LMC's are encouraged to complete a one day course to be certificated in order to carry out intubation procedures in the context of advanced neonatal resuscitation. However, it is also our understanding that as a minimum requirement, an LMC is not currently expected to be proficient in the procedure. We submit that this is inadequate, and that LMC's should have the benefit of significantly more training and experience if in their practice they intend to attend births outside of a secondary or tertiary hospital environment.

X. In an effort to expedite parental participation in the birth process, and, informed consent in atypical situations, we submit that any guidelines, recommendations and minimum standards that are finalised in the context of this review should be provided to expectant parents as a matter of course, from such sources as their LMC, nurse, doctor or specialist.

XI. Experiences within our membership indicate that the term LMC can be a source of confusion. The facts of a recent high profile case indicate that this confusion can extend to health professionals. This is especially so where transfer of care and responsibility has taken place but where the title Lead Maternity Carer remains. In that context the word “lead” is misleading. We submit that health professionals should use the titles that will cause the least confusion to the public and to their own profession. On that basis, doctors should be called doctors, and midwives should be called midwives.

ENDS