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Tēnā koe Catherine

Ministry of Health Maternity Referral Guidelines

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the review of the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).

The Royal New Zealand College of General Practitioners is the largest medical college in New Zealand. Our membership of 5,500 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

Submission

The College welcomes this review of the Guidelines which were last revised in 2012 and were scheduled for review in 2016.

We note the Referral Guidelines were intended to:

1. improve maternity care safety and quality
2. improve the consistency of consultation, transfer, and transport processes
3. give confidence to women, their families and whanau, and other practitioners if a primary health care or specialist consultation, or a transfer of clinical responsibility is required
4. promote and support coordination of care across providers.[1]

The 'primary' referral category

The College welcomed the new category of referrals to primary care when it was added in 2012. The new category was intended to enable pregnant women with medical conditions most appropriately managed in primary care to be seen by general practitioners rather than referred to secondary care. This is the first review of the Guidelines since the addition of this category.

While the College was pleased to see the addition of the 'primary' category we are concerned that this category is not being utilised in a way that facilitates the best outcomes and experience for pregnant women.

[1] https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf
Accessed 7/5/21 Page 1

Reluctance to refer to specialist general practitioners

Our members commented that they considered that lead maternity carers (LMCs) were reluctant to refer women to specialist general practitioners. Cost is one contributing factor, and is discussed later in this submission, but the College would be keen to see work to identify other contributing factors**.** We question whether LMCs understand the skill set of vocationally trained specialist general practitioners, and whether this is contributing to continued inappropriate referrals to ED and secondary care.

Responses to survey questions

Questions 10 and 11: Do the processes for referral/transfer of care in the Referral Guidelines reflect best practice? What changes do you suggest?

Our comments relate to Section 4.1 (p8) and to Process Map 1: Referral to primary care (p9).

Our members are experienced at making referrals and conscious that for the patient to receive effective appropriate care, the reason for the referral and appropriate contextual information must be conveyed clearly. Such communication is an essential component of a referral. Indeed, if their referrals are not of good quality, GPs can expect to receive feedback from the GP liaison employed by the appropriate DHB service.

Our members tell us that referrals from LMCs are often not accompanied by appropriate information and pregnant women themselves may be unaware of why the midwife has suggested they see their GP. In such situations the issue of concern to the LMC may not be addressed with consequent risks to the quality of the care provided to the woman. We consider that it is clinically important for the quality of care that more emphasis on the quality of the referral from the LMC should be included in the guidance.

While the guidelines do not specify the information that must be contained in the referral communication to the general practitioner, they do specify that "The LMC must advise the woman that there may be a charge to her for her consultation with a GP or other primary care provider."[2]

The College considers that when seen alongside the lack of explicit guidance regarding the content of the referral, the inclusion of explicit instructions regarding advising the woman of the likely cost of the appointment provides a revealing insight into the environment in which referrals to general practice are (or are not) occurring. We consider that a reversal of focus and priorities needs to occur and removing the statement about charges would assist this change. Adequate funding of primary health care for pregnant women would remove any need for such a message. We discuss funding later in the submission.

A secure electronic communication channel between GPs and LMCs has been needed for more than a decade. The National Health IT board started work on improving the communication between clinicians in the maternity sector, prior to 2010 [3] but the sector and pregnant women are still waiting. The ability to securely share information digitally would go a long way towards facilitating the much-needed improvements in communication between LMCs and the other health providers involved in the care of pregnant women.

[2] https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf Accessed 7/5/21 Page 8

[3] https://www.health.govt.nz/system/files/documents/publications/national-health-it-plan-v11.pdf

Question 12. Could changes be made to the processes for referral/transfer of care in the Referral Guidelines to improve equity?

The direction to LMCs to advise the woman that there may be a charge for her GP consultation reflects the extent to which cost is a barrier to the provision of non-maternity care for pregnant women. This barrier operates on two levels; the individual patient who may not attend due to concerns regarding the ability to afford the co-payment, and the LMC who is reluctant to advise the women that she should see her GP because of the cost involved.

Given that the Guidelines state that "The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care"[4] , the College believes that there is a lack of emphasis here on the needs of the woman, her baby and the family / whānau. Prioritising awareness of possible co-payments over the importance of providing sufficient information as to the clinical and other needs of the woman that have indicated a referral, does not place the woman, her baby and family/whānau at the centre of the conversation.

In terms of truly improving equity for pregnant women, babies and whānau, the College continues to recommend that all care during pregnancy should be free to the patient regardless of whether or not it is maternity care. This is the single most important change that would improve equity by providing universal access.

Question 14 Are the Referral Guidelines categories of referral appropriate?

The College considers that a category of urgent referral should be added to cover those conditions which do not require a transfer of care, but do require an ***urgent*** consultation, e.g. acute abdominal pain, acute pyelonephritis.

Question 18. Are there conditions that should be added to the Referral Guidelines?

Influenza like illness is currently the only condition categorised as 'primary' which is listed under 'current pregnancy'. There are many more conditions that should be included.

It is not useful to list all the symptoms that women of childbearing age might experience where consultation with a general practitioner would be advisable. Instead LMCs should be advised to encourage women with symptoms suggestive of conditions that are outside of maternity care and their scope of practice, to consult their general practitioner.

If the woman does not have a general practitioner this should be considered a red flag. It is important for the care of the woman and her baby that she is encouraged and assisted to enrol with a practice.

While not a clinical 'condition' non enrolment could also be included in the referral guidelines as requiring action.

Feedback from Rural Hospital Doctors

The College received feedback from several Rural Hospital Doctors who expressed concerns related to the use of the guidelines in rural areas.

They considered that the guidelines were not always being followed and as a result, women with conditions classified as requiring a consultation with an obstetrician, were not being seen by an obstetrician and were

[4] P 7 of the Guidelines

birthing in rural birthing units inappropriately. They questioned whether adherence to the guidelines needed to be strengthened.

They also requested clarity on whether health practitioners who accompany women transferred via helicopter should be required to be familiar with helicopter protocols.

Data collection

We note that each of the indications for referral is allocated a code. We would be interested in knowing whether data is collected on the referrals made and whether this information is available. Analysis of such data, if it exists, would inform changes to the Guidelines. The College considers that if data is not currently collected this should be considered in future to inform outcomes of maternity care.

Collecting data on the percentage of pregnant women who are not enrolled with a general practice should also be considered. Data collection would assist in prioritising this issue and would enable identification of areas with particularly low levels of enrolment where additional measures may be necessary to ensure that all pregnant women and their whanau have access to their own specialist general practitioner.

Conclusion

The College is keen to see integration between general practice and maternity care that advances the wellbeing of whānau expecting a baby. We are keen to be involved further in the process around the review of these guidelines, and in other work that the Ministry may undertake to improve integration and collaboration between LMCs and general practitioners so that our different and complementary skillsets can be combined to better support pregnant women and their babies.

We hope you find our submission helpful. If you have any questions, or would like more information, please email us at policy@rnzcgp.org.nz

Nāku noa, nā

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Appendix 1

Conditions with a referral category “Primary”

Extracts from table 2 p 21-30

		Code	Condition	Description	Referral category
Pre-existing and/or co-existing medical conditions	Cardiac	1007	Arrhythmia/palpitations; murmurs	Recurrent, persistent or associated with other symptoms	Primary
	Endocrine	1022	Thyroid disease	Hypothyroidism	Primary
	Gastroenterology	1025	Cholelithiasis	Symptomatic	Primary
	Gastroenterology	1028	Inflammatory bowel disease	Inactive	Primary
	Infectious diseases	1048	Tuberculosis	Contact	Primary
	Neurological	1051	Epilepsy	Controlled	Primary
	Mental health	1058	Current alcohol or drug misuse/dependency		Primary
	Mental health	no code	Depression and anxiety disorders		Primary
	Respiratory Disease	1066/1067	Asthma	Mild or moderate	Primary
	Respiratory Disease	1069	Acute respiratory condition		Primary
Previous maternity history		3018	SUDI (Sudden unexplained death of an infant)		Primary
Current pregnancy		4033	Influenza-like illness		Primary
Services following birth – mother	General	7004	Postnatal depression		Primary
Services following birth – baby	Genitourinary	8001	Abnormal neonatal examination	Minor abnormalities not specified elsewhere	Primary
	Genitourinary	8030	Undescended testes		Primary
	Maternal Factors	8048	Maternal medication with risk to baby	E.g. carbimazole, antipsychotics, antidepressants, anticonvulsants	Primary