THE PAEDIATRIC SOCIETY OF NEW ZEALAND

Secretariat: Denise Tringham
P O Box 22 234
Wellington
Tel: (04) 938 4827
Fax: (04) 976 4827
Email: psnz@paradise.net.nz

21/9/06

Comments on Proposed Section 88 Notice For Primary And Maternity Services

The Paediatric Society is a multidisciplinary organisation with over 400 members. The aim of the Society is to work as a coordinated national network of health professionals helping children and young people to attain optimal physical, mental and social health and well being. Our members include most paediatricians and also nurses, midwives and groups of allied health professionals who work with children and young people.

Thank you for the opportunity to comment on the proposed Section 88 Notice. We note some of the areas of the Notice will provide opportunities to improve the care of mothers and their babies. Some areas of the Notice need significantly more detail. Other areas of the Notice cause concern.

Quality Issues:

1. We support the earlier hand-over of newborn infants from their LMC to their Well Child Team and General Practitioner. This earlier hand-over should promote connectiveness to Well Child Services and offer support with greater focus on the infant. We do however, believe there needs to be flexibility in the date when the LMC ceases care. At times, continuing LMC care beyond four weeks may be in the best interest of mother and child e.g. to support lactation, where a gap would occur to access the well child provider in rural or remote areas. Also a period of overlap between Well Child Services and LMC can be beneficial in supporting continuity of care.

2. In a number of places within the document, mention is made of more detailed documents. It is vital that these documents are seen as a key part of Section 88 and not an after-thought. We believe it is important that they are published either within the Section 88 Notice or as clear appendices to this notice. Elements of particular importance are;

    a. Recommendations for screening and risk assessment in early pregnancy so that infant-related issues are addressed in a timely manner eg HIV,
    b. Recommendations for risk assessment to reduce the frequency of delivery in situations of needless risk e.g. breech in the primary setting.
    c. Clear referral guidelines with regard to consultation or transfer of care to Paediatric and other services. Appendix 1 in 2002 document. Ultrasound referral guidelines for babies need to include screening for developmental dysplasia of the hip e.g. for Breech and family history. As well as follow up of antenatal ultrasound abnormality.
    d. Standards and guidelines for newborn care. This includes the mention already made of the Tamariki Ora National Schedule Handbook. It would be beneficial if the key pages were published as an appendix. Also a draft template for an Infant Care Plan offering check lists, etc. could also be positioned as an appendix.
    e. A clearer list of issues related to anticipatory guidance such as advice on immunisation, administration of Vitamin K, smoking cessation, preparation for breast-feeding, use of alcohol, hearing screening, shaken baby and SIDS prevention etc, could be valuable for LMCs.
    f. A specific template around metabolic screening should also be included referring to the information given to families, timely collection of blood specimens (48 hours), appropriate timing of sending of blood specimens to the national Testing Centre and responsiveness to results as they are returned.

Funding Issues

1. Within District Health boards, substantial amounts of maternity care occur, which is and should be primary care. An advantage of this occurring in the DHB setting is ease of access to secondary care. It is important that secondary care should be able to support primary care without the transfer of care occurring.

   The current system of payments for attendance at delivery and consultations works well allowing care in what is perceived to be "the best place for the baby". Currently when a mother and baby are in a primary care setting or a private birthing unit and they experience problems,(e.g where it is impractical or unsafe to transfer the labouring woman), the LMC contacts a paediatrician with advanced neonatal resuscitation skills who attends the primary care setting and provides expert paediatric care.

   So that good working relationships between primary and secondary care can be maintained and fostered, it is important to retain a funding environment that does not provide any perverse incentives promoting inappropriate transfer of care or delayed consultation.

   It is not clear in this new proposal how secondary care paediatric services will be funded to offer care within the primary care arrangements. It appears that there is now no payment for a paediatrician to attend a delivery. A solution to this would be to reinstate the payment template that exists currently. Failure to do so potentially puts mother and baby at risk and also serves as a barrier to early referral from LMC to specialist paediatric services.

2. We note the intention of this notice to shift significant elements of care from primary to secondary care. We do not believe it is in the best interests of infants to be forced to have care transferred from primary to secondary care because of funding requirements. Many interventions, e.g. paediatrician attendance at delivery or consultation can and should occur in what is primarily a primary care context even if on DHB property. The intervention from the Paediatric Service being only brief, prior to care continuing within primary care. In this context, attendance at delivery is really a consultation rather than a transfer of care. The Notice needs to support the care that is best for mothers and their babies, which will mostly be primary care, wherever safe and appropriate. We also fear the need to transfer care may become a barrier to referral or seeking help.

3. The requirement to have a written referral for each consultation is accepted in the context that the midwife identifies a non-urgent need for examination by a paediatrician (as per referral guidelines). Where this is required for onset of acute symptoms then verbal referral needs to be acceptable. Subsequent consultation of a paediatric condition eg heart murmur, significant jaundice under phototherapy should not require a further written referral.

4. The fee schedule for the majority is unchanged from 2002 and in some cases fees are reduced. This undervalues the important paediatric work carried out and is likely to reduce access in areas which already have a shortage of LMC's either midwives or GP's.

   We hope you find these comments helpful. We support he call by the NZCOM that a multidisciplinary forum of all involved parties be held so that an improved Section 88 is developed that best meets the needs of mothers and their babies. We will be very happy to meet with you and discuss these issues in more detail if you feel it appropriate.

Regards

Nick Baker
President
Paediatric Society of New Zealand

Nicola Austin
Chairperson
Fetus and Newborn SIG
Paediatric Society of New Zealand