New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

3 May 2019

Ministry of Health
New Zealand Obstetric Ultrasound Guidelines 2019 Consultation

Feedback from: New Zealand College of Midwives
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The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent 90% of the practising midwives in this country. There are around 3,000 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to on average 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby. It provides women with the opportunity to have continuity of care from a chosen maternity carer (known as a Lead Maternity Carer or LMC) throughout pregnancy and for up to 6 weeks after the birth of the baby, and 92% of women choose a midwife to be their LMC. Primary maternity services provided by LMC midwives are integrated within the wider primary care and maternity services of their region or locality. The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and well-being.

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Dear Moira

Thank you for giving the College of Midwives an opportunity to provide feedback on the NZ Obstetric Ultrasound Guidelines. We have consulted with our members on the draft guidelines and would like to provide the following feedback.

The College believes that there has been an urgent need for consistency of ultrasound services for some time and that these guidelines are an important step to supporting equitable ultrasound services for women during childbirth in New Zealand.

Lack of stakeholder involvement

Our members have expressed disappointment with the development process of the guideline and that key stakeholders such as the College of Midwives, consumer groups and RANZCOG have been excluded from the guideline development process. The AGREE II guideline tool identifies that when developing a high quality guideline it is extremely important to ensure that all stakeholders are involved. The majority of women have a midwife provide continuity of care as their Lead Maternity Carer during childbirth. It is the LMC who will assess the woman's health and wellbeing and following an informed discussion identify when and if ultrasound scans for screening or diagnostic purposes are required. We understand and acknowledge that these guidelines are aimed primarily at ultrasonography services, but they will also affect midwives, obstetricians and women. We believe the views and preferences of all stakeholders should have been sought and represented during the development of the guideline and not left for the consultation phase.

Clinician and public awareness and education will be required

In general our members are supportive of the guidelines and believe that they will improve the consistency of services. We agree it is important to identify that ultrasound scans should only be offered as part of a screening process for fetal anomaly or for specific clinical indications and that for women with an uncomplicated pregnancy there is no need for additional ultrasound scans unless specific clinical indications become apparent during the pregnancy.

In their feedback, our members have identified concerns that general practitioners will often order a dating scan as part of routine tests during early pregnancy and that women also frequently consider early scans as the 'norm' and will sometimes request additional scans.

We were also told of some ultrasonography services which provide 'social' scans where women are offered a package of scans (which include early dating, nuchal, anatomy and growth scan at 32 weeks) without reference to the woman's risk status, health or wellbeing.

These points demonstrate a culture of expectation and belief within society that scans are socially acceptable, routine and a necessary part of maternity care. Our members reiterated that:

> '*Scanning is a clinical procedure and should be used only with a clinical indication, apart from those offered as components of screening.*'

Unnecessary scans are costly to the health system, and when done routinely there may be a lack of informed consent. The culture of expectation of frequent routine scans will need to be addressed through education and/or public promotion to support clinician's and women's awareness and adherence to the guidelines. It will be important to ensure that there is a pathway identified to increase public awareness so that general practitioners, other clinicians, women and their families are aware of these guidelines and the expectations related to ultrasound scans.

Audit

We support the intent of the guidelines to improve consistency and expectation for ultrasound scanning. Ultrasound is currently frequently overused and we have also been told by our members that some ultrasound services have a high proportion of women who 'need' a repeat scan. These may be due to legitimate reasons but there is also suspicion that they are a method of increasing revenue. We would request that once the guidelines have been accepted and disseminated, that there will be plans to audit the services to ensure they are meeting the guidelines. Audit should include the number of repeat scan requests due to 'lack of ability to visualise anatomy' as a quality measure to identify service outliers. We believe that monitoring and reporting on this issue may change behaviour.

Feedback to ultrasound services

Members also identified issues with unwelcome comments and advice related to the scan findings and which frequently increased the woman's concern and anxiety. Clinical decisions are often taken based on ultrasound assessments, especially when related to fetal size, despite the lack of accuracy of this measure. At present there is no consistent or formal feedback mechanism for ultrasound services and our members have suggested a formal consumer and clinician feedback opportunity should be provided.

> *I would like to suggest that a monitored online feedback opportunity for LMCs and service users to input data back to radiology services be established at every radiology service. This would be extremely useful for quality improvement processes. For example, collecting outcome information regarding estimated fetal weights, cord insertions, placental location problems, and, most importantly, women's experience of their ultrasound appointment would be highly beneficial. I am sure services have feedback mechanisms for collecting service user feedback, but for example a number of clinical decisions - including induction of labour and elective caesarean section decisions, are being made on the basis of estimated fetal weights and the concomitant anxiety this produces in both pregnant people and clinicians. Collecting data on accuracy could be reassuring, or prompt considered improvements to reduce anxiety.*

Being able to provide feedback to the services is important for both clinicians and women. Midwives receive consumer feedback (through the College feedback system) which is an essential quality mechanism for midwives. We consider that sonography services could and should do something similar so that they can be provided with feedback from both clinicians and women.

We have provided specific feedback on each sections of the guideline below

Templates and colour coding
Our members support the use of reporting templates to ensure consistency of reporting requirements from ultrasound services to maternity clinicians. We believe these will support improved communication and understanding of the ultrasound findings.

We welcome the use of coloured reporting alerts to identify the urgency of reporting back to the requesting clinician.

First trimester
We agree that routine ultrasound should not be offered or requested to confirm pregnancy and should ideally be offered between 12 and 13+6 weeks gestation for viability, gestational age, number of babies, fetal anatomy and nuchal translucency (NT) as part of the risk assessment for aneuploidy.

In the list of indications for early pregnancy scans of less than 12 weeks we wonder whether the point – pregnancy with an IUCD in situ could be changed to – increased risk factors for ectopic pregnancy. This would then include both a failed IUCD and failure of the morning after pill.

Within the required clinical details – could the language be changed from 'patient' to 'woman' to make the document more women friendly? It is only women who become pregnant and require an obstetric ultrasound. Patient comes from the Latin word related to suffering – women are generally not 'suffering' or in need of medical treatment when pregnant.
We would also like to suggest that instead of a history of previous caesarean section this could be extended to a history of uterine surgery (including previous caesarean section).

Non-invasive prenatal screening (NIPS)
We are unclear as to why there is a section on non-invasive prenatal screening (NIPS) in a guideline about ultrasound scanning. NIPS is not currently a publicly funded screen and access to it is currently inequitable due to cost and accessibility. Whilst the information is interesting we fail to understand why information on NIPS is provided within a guideline seeking to provide detailed information about maternity ultrasound scans. We are also concerned that in *the NT reporting guide and pro forma* that NIPS is being recommended when a woman presents too late for an NT assessment. By providing this information and recommendation it may appear that the guideline is advising or promoting the use of NIPS which is a service provided by private providers. If this is to remain in the guideline then it needs to also clarify that NIPS requires funding by the consumer.

Cervical length screening
Generally, the information in this section is very useful. We are however concerned that the imaging protocol identifies that "*for high risk women*, *cervical screening should be performed every two weeks".* Although this is useful information we believe it should be the maternity clinician who should identify the frequency and request the follow up scans. Therefore it should not be a requirement within the protocol.

Anatomy screening
The section on anatomy screening appears comprehensive; we were pleased to see the advice that soft markers should be considered an isolated finding and not reported.

We are concerned about the use of the term 'incompetent cervix' in this section and suggest that the previous terms be used – for example – open cervix +/- bulging membranes or short cervices <25mm. This will also support consistency throughout the document.

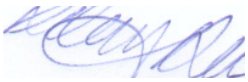
Third trimester
The indications for a third trimester ultrasound scan appear to be comprehensive but note there is no definition of oligohydramnios within the document.

Third trimester reporting pro-forma
We note the reference to the use of GROW – which is a customised growth chart. There are a variety of customised growth charts that can be used, with GROW being predominant within New Zealand. However, we question the need to recommend the use of this specific type of customised growth charts within the guideline. In addition we are concerned that there is a recommendation that GROW be used. Currently GROW is used in some parts of New Zealand and by some clinicians but not all. There are access, and education requirements associated with this programme and funding to ensure equitable access for all clinicians to the programme has not yet been identified. Care needs to be taken when making recommendations to other professional groups.

Doppler
In this section there is again reference to GROW charts, please could this be changed to either a population based growth chart of a customised growth chart. As previously stated, not all clinicians will have access to the GROW charts so there needs to be a means of supporting a scan when there are concerns related to growth.

Summary
In conclusion the College supports the intention and the majority of information within this guideline. We consider that it important that **all s**takeholders are involved in future guideline development related to maternity care especially when they will influence other clinicians. We believe that a public awareness and education campaign will be needed to support the operationalising of the guidelines and to support understanding for clinicians and women. We also would like to see plans for future auditing and a requirement for feedback mechanisms identified within the guideline. We believe that these will support improved quality and consistency of ultrasound services.

Yours sincerely



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