



AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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PERINATAL & MATERNAL MORTALITY IN 2012

The Perinatal and Maternal Mortality Review Committee (PMMRC) recently released its report on perinatal and maternal mortality in New Zealand for the year 2012. This is the committee's eighth PMMR report. This year the report includes data on babies who died in New Zealand between 2007 and 2012, and mothers who died from 2006 to 2012.

For the first time it includes a multivariate analysis using the national maternity dataset which investigates whether ethnicity, age, socioeconomic status, body mass index (BMI), parity and smoking are associated with stillbirth and neonatal death.

There are also two special topic analyses on full term unexplained stillbirth and term intrapartum (during labour and birth) related perinatal death. Unexplained stillbirths were studied because they make up the largest proportion of perinatal deaths at term.

Maternal mortality in 2012

There were two direct maternal deaths, and eight indirect maternal deaths. A direct maternal death is one that is the result of obstetric complications during pregnancy, birth and up to 42 days postpartum, and from interventions, omissions or incorrect treatment. An indirect maternal death is one that is the result of a pre-existing disease or a disease that developed during pregnancy that was not due to obstetric causes, but was aggravated

by the physiologic effects of pregnancy.

The causes of the two direct maternal deaths were sepsis and an amniotic fluid embolism. The eight indirect deaths included three suicides, four mothers with pre-existing medical conditions, and one mother who suffered an intracranial haemorrhage.

Seven years of data

The 77 direct and indirect maternal deaths from 2006-2012 included:

- 26 antepartum and 51 postpartum
- 49 occurred in hospital and 28 in the community
- 50 births, 26 undelivered babies and one unknown.
- 26 with potentially avoidable factors present, 47 with none and four were unknown.

Pre-existing medical disease and suicide were the most frequent causes of maternal mortality in New Zealand in 2006 – 2012.

Suicide

Of the 48 indirect maternal deaths during this seven-year period 19 were a result of suicide.

Potentially avoidable deaths

The report notes that in the seven years from 2006-2012 the MMR working group believed that 33.8% of maternal deaths were potentially avoidable. The problems that were identified as having contributed to these deaths were caused by either organisational/management failings, personnel failings, or barriers to access.

Organisational problems

The major factors involved in the potentially avoidable deaths included

17 cases relating to lack of policies, protocols or guidelines, 12 relating to inadequate systems/process for sharing of clinical information between services, 10 relating to inadequate education and training, five relating to poor organisational arrangements of staff, four relating to a failure or delay in the emergency response, four relating to equipment or building and design functionality, two relating to poor access to senior clinical staff, and two to a delay in procedure, eg caesarean section.

Barriers to access

The barriers to access included seven women with maternal mental illness, ten with no or infrequent antenatal care, three with language or cultural barriers, and one who was not eligible for publicly funded maternity care. Substance abuse featured in seven potentially avoidable maternal deaths, family violence in four, and a lack of recognition of the complexity or seriousness of the condition in 11 cases.

Deprivation

Maori and Pacific mothers are three times more likely to die of direct and indirect causes in pregnancy or in the 42 days following the end of pregnancy. The report states that “there is increasing risk of maternal mortality with increasing socio-economic deprivation.”

Over the years 2006-2012 approximately 25% of mothers who died were having their first baby, while a further 25% had had more than four prior births. Fifty-eight percent of the mothers were overweight or obese. The report also notes that “the rate of smoking among mothers who died (36%) is

high compared to previous estimates of smoking among mothers in New Zealand.”

Perinatal mortality

In 2012 there was a total of 669 perinatal related deaths – perinatal mortality being foetal and neonatal deaths of babies born from 20 weeks gestation who die in utero, or within the first 27 days of life of any cause. Excluding the 225 perinatal related deaths caused by lethal and terminated foetal abnormalities brings the total down to 444.

The report notes that the total perinatal related mortality rate has overall been stable over the years 2007 – 2012 using the New Zealand definition above.

The most common cause of perinatal death in NZ is congenital abnormality which accounts for 30% of deaths. The second most common cause is spontaneous preterm birth which accounts for 15% of all perinatal deaths and is the cause of a third of neonatal deaths.

Stillbirth

There has been a reduction in stillbirth from 2007 to 2012 which is independent of demographic changes. The reduction is significant for deaths at 41 weeks gestation and over. There has also been a significant reduction in the proportion of births in NZ at 41 or more weeks gestation which the report says may be due to higher rates of induction of labour in pregnancies at 41 or more weeks gestation.

Stillbirth is most often unexplained and this year’s report contains an analysis of the separate effects of the known predictors of stillbirth and

neonatal death. Excluding deaths from congenital abnormalities, the significant predictors were:

- women of Indian ethnicity
- smoking in pregnancy
- BMI greater than 25, with an increase in risk with increasing BMI
- women having their first baby.

Recommendations

This year's report includes two recommendations relating to maternal mortality which are similar to those made in last year's report. They are:

- Women who are clinically unwell or unstable should be cared for in the most appropriate place within each unit in order for close observation to occur. When observations are abnormal, clear documentation, early review by a senior clinician and development of a detailed management plan are required.
- Women with serious pre-existing medical conditions require a multi-disciplinary management plan for the pregnancy, birth and postpartum period. This plan must be communicated to all relevant caregivers.

The recommendations relating to perinatal mortality concern the risks posed by smoking during pregnancy, a high BMI, and the impact of socio-economic deprivation on perinatal death. The last recommendation says:

- The PMMRC recommends that Northland, Tairāwhiti and South Canterbury DHBs review all cases of intrapartum related death at term in their area to identify opportunities for improvement.

The PMMRC report can be found at:

<http://www.hqsc.govt.nz/publications-and-resources/publication/1576/>

NATIONAL WOMEN'S ANNUAL CLINICAL REPORT DAY

Time: 8am – 4pm

Date: Friday 15 August 2014

Venue: Clinical Education Centre,
5th Floor, Auckland City Hospital.

Cost: Free registration.

The programme for this year's Annual Clinical Report day includes:

- Critique of the 2013 maternity report by Dr Rose Elder
- Neonatal presentations
- Critique of the 2013 gynaecology report by Dr Peter Can Der Weijer
- Review of the use of vaginal mesh
- The Waitemata/Auckland DHB Women's Health Collaboration
- Review of Colposcopy
- Review of Management of GDM by Dr Rose Elder
- Early Registration with an LMC
- Abnormal Uterine Bleeding
- Neonatal Hypoglycaemia by Dr Deborah Harris
- Helping families understand the process of perinatal autopsy

Registration is essential.

Further information is available at:

<http://nationalwomenshealth.adhb.govt.nz/health-professionals/annual-clinical-report>

CERVICAL SCREENING TARGET REMAINS, BREAST CANCER SCREENING GOES

On 1 July 2014, while cervical screening remained as one of five health targets that Primary Health Organisations (PHOs) are required to meet by the District Health Boards and the Ministry of Health, breast cancer screening was dropped.

That wasn't the only change that came into effect on 1 July. The PHO Performance Programme (PPP) which the country's 31 PHOs were all enrolled in was replaced by the new Integrated Performance and Incentive Framework (IPIF). Just why the Ministry of Health decided to change the name is a bit of a mystery. It's bound to have something to do with that word "integrated" and with money.

According to the MOH website the aim of the PPP was "to improve the health of enrolled populations and reduce inequalities in health outcomes ... through supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against a range of nationally consistent indicators will result in incentive payments to PHOs." (1)

Whereas the new IPIF is a quality improvement and performance improvement programme that ... will support the health system to address equity, safety, quality, access and cost of services." (2)

Maybe it's got something to do with the difference between "incentive payments" and "costs of services." The PHOs probably understand the

difference, even if their patients have no idea of what is going on.

Of course with such a significant name change there needs to be a transition year as the IPIF isn't fully developed yet. During the 12-month gestation period the PHOs will be required to implement the following measures/targets:

- cervical screening coverage (80%)
- more heart and diabetes checks (90%)
- better help for smokers to quit (90%)
- increased immunisation rates at eight months old (95%)
- increased immunisation rates at two years old (95%)

So the next time you make an appointment to see your GP, don't be surprised if s/he is focused on getting you to have heart and diabetes checks, helping you get off the ciggies, and insisting on your having a cervical smear, rather than finding out what matters to you. They have to meet their targets, because "all PHOs will be expected to meet and/or maintain performance at the national target by 30 June 2015." (2)

Money

Here comes the bit about the money: "The \$23 million budget for the PPP will remain, but realignment of rewards for performance will see changes in payments to PHOs/general practices, with cervical screening comprising 25% of the quarterly target payment." (2)

References

1. <http://www.health.govt.nz/system/files/documents/pages/phoperfmagmtsummaryinfo.pdf>
2. <https://www.nsu.govt.nz/news/5678.aspx#5681>

How GPs Meet their Targets

The AWHC recently received the following story about how efforts to meet these targets affect patient care:

“A few months back my ‘significant other’ (SO) received a letter from his General Practice recommending that he have a Cardiovascular Risk Assessment. A blood test form was included because he needed at least one more blood test before the assessment could be done. The letter indicated there would be a fee charged for this visit but it didn’t say how much it would be.

We had a discussion about this, as you do. He had just had some blood tests done. Why hadn’t they included this one at the same time to save him another visit to the laboratory and another bruised arm? He had given up smoking, he was on blood pressure medication as well as a statin that were controlling his BP and cholesterol effectively so there was likely to be minimal benefit, and certainly not enough to warrant additional visits and a fee. The decision was made not to take up the offer, although we expected it wouldn’t be well received because it wasn’t going to help the practice and the PHO meet its target and receive an incentive payment.

A couple of weeks later the phone duly rang. It was someone from the Practice with a reminder for the SO to come in for his Cardiovascular Risk Assessment. This was not unexpected as the Practice runs an efficient follow up system, and after all, there was a target to be met. I suspect the caller may have been disappointed when I advised the not-negotiable decision to leave the assessment

until the SO could combine it with his next GP consultation.

That time came when the SO was summoned to discuss a problem that had arisen from the latest round of blood tests. That sort of summons requires a support person just in case the news is really bad. But it was manageable. The blood pressure pills were controlling the SO’s blood pressure very well, but were having a continuing negative impact on his kidney function. It was necessary to change the brew. That was carefully explained and very constructive.

Then it was time for the Cardiovascular Risk Assessment. Without further ado there was a switch to another screen on the computer, the requisite details recorded in the boxes, and the built in calculator did its thing. The SO was advised he had a 15% chance of having a heart attack/cardiovascular event in the next 5 years; that at 15% he needed to be treated; but hey, he was already being treated so no further action was required. We weren’t informed where the SO’s information in this box ticking exercise went, whether it was identifying or anonymised and for what other purposes it might be used.

Our initial view, that there would be no added benefit for the SO from undergoing this assessment was confirmed. But from the GP/PHO perspective, the boxes had been ticked, another person’s risk assessed; another number towards meeting the PHO target and the associated incentive payment.

It’s difficult not to take a cynical view of this sort of target driven behaviour. Just whose needs is it meeting? Is this our expectation of patient-centred care?”

CAESAREANS INCREASE RISK OF ECTOPIC PREGNANCY AND STILLBIRTH

A large study in Denmark revealed that caesarean sections increase the rate of ectopic pregnancies and stillbirths in subsequent pregnancies.

The population-based cohort study which was published at the beginning of July 2014 in *PLOS Medicine* was conducted by researchers at University College Cork in Ireland and Aarhus University in Denmark and looked at 832,996 women from Danish national registers and followed their progress after their first live birth. (1)

The researchers found that women who had previously given birth by caesarean section have a 14% increased rate of a stillbirth in their next pregnancy, and a 9% increased rate of ectopic pregnancy, but do not increase the rate of subsequent miscarriages. The researchers controlled for the possibility that the caesarean section might have been performed due to an underlying problem.

“The findings of the current study are particularly important for expectant mothers as well as healthcare professionals as caesarean section rates are increasing significantly worldwide,” researcher Professor Kenny said. (2)

Caesarean section has also been associated with an array of subsequent health problems for the baby. A study published last year in *Health News Today* revealed that babies born via caesarean section are five times more likely to develop

allergies, (3) and another more recent study indicated that caesarean birth puts the baby at an increased risk of diabetes and obesity as an adult. (4)

References

1. <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001670>
2. www.techtimes.com/articles/9544/20140703/c-section-may-increase-risk-of-stillbirth-and-ectopic-pregnancy-in-future-warns-new-study.htm
3. www.medicalnewstoday.com/articles/278978.php
4. <http://www.medicalnewstoday.com/articles/273321.php>



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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for July/August 2014:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)

The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 13 August 2014 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 30 July 2014.

Auckland DHB (Website address: www.adhb.govt.nz)

The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 6 August 2014 followed by the Full Board meeting at 2pm. Both meetings will be held at the Marion Davis Library, Building 43, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 13 August 2014 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 20 August 2014 at 19 Lambie Drive, Manukau City.



ETHICS COMMITTEE meetings – dates for the four new ethics committees are at: <http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes>



The Breast Cancer Network NZ is holding a Seminar on “**Reducing Breast Cancer Risk**” on Saturday 30 August 2014 at Kings School, 258 Remuera Road, Remuera, Auckland.

The day’s programme includes:

- Professor Ian Shaw on “Breast Cancer – nature or nurture?”
- Dr Helen Smith on “Dietary and lifestyle risk reduction.”
- Dr Peter Tanbridge on “There is more to breast cancer than genes>”
- Liz Hart on “Emotional Freedom Techniques”
- Sue Dykes on “Mindfulness based stress reduction.”

To register contact Bonnie on: admin@bcn.org.nz or phone (09) 636-7040.