Te mate pēpi | Perinatal mortality

Perinatal mortality appendix: Update on previous neonatal mortality recommendations

1. The PMMRC recommends the Ministry of Health establish a multidisciplinary working group to review current evidence for implementation of a preterm birth prevention programme such as that implemented in Western Australia, taking care to: a. identify and adequately resource evidence-based solutions b. ensure equitable access to screening and/or treatment for priority populations c. ensure that priority populations have a voice in the development of health policy, process and practice in order to achieve equitable health outcomes d. ensure that the outcomes of any implemented programme, including equity of access, are evaluated.	**The Ministry of Health** shares the PMMRC's desire to see progress in reducing preterm birth and reducing inequalities in the maternity system. Over the past 10 months, the Ministry of Health has been working on planning and developing a whole of maternity system action plan that will be considered by Cabinet in the middle of the year. This action plan will direct the transformation of maternity services from 2019–2023 to ensure the maternity system is effective, sustainable and remains a world-class service. While this work is in a planning phase, through the Maternity Quality and Safety Programme (MQSP) every DHB has been asked to undertake and report on the following projects in the 2018/19 work programme: • reducing preterm birth and neonatal mortality • improving care for mothers under 20 years of age • accessing primary mental health services • promoting primary birthing where appropriate.
2. Women with a previous preterm birth at less than 34 weeks are at increased risk of neonatal death. The PMMRC recommends that LMCs and DHBs employ strategies to reduce preterm birth by targeting this high-risk group, including: a. counselling at the time of a preterm birth to outline the strategies likely to be recommended for their next pregnancy, and advice to present for antenatal care as soon as they know they are pregnant b. ensuring that antenatal care is available to allow women to register as early as possible, and ensuring that early antenatal care includes attention to modifiable risk factors such as smoking, sexually transmitted infections, and urinary tract infections c. ensuring referral for specialist consultation in the first trimester to facilitate discussion of treatment options, which might include cervical cerclage or vaginal progesterone	**The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)** plans to highlight and discuss this recommendation at the Clinical Directors and Midwifery Leaders meeting in August 2019. RANZCOG will also recommend that counselling at the time of preterm birth and strategies for possible future pregnancies be prominent in both DHB and RANZCOG guidelines as a best practice recommendation. **The New Zealand College of Midwives (NZCOM)** notes the expanding evidence base that describes the protective effect of midwifery continuity of care on preterm birth rates with a particularly strong protective effect for women of low socioeconomic position. The New Zealand model of maternity care is premised on continuity from a known midwife, and NZCOM consistently promotes and supports midwives to provide continuity of care as well as advocating for this model to be sustained as part of the New Zealand health system.

treatment and monitoring of cervical length using transvaginal ultrasound d. counselling around signs and symptoms of preterm birth and how to respond to these to optimise outcome.	NZCOM has developed and manages the Find Your Midwife website, which enables women to access up-to-date information on midwives availability and contact details. It is standard midwifery practice as expressed in the competencies for entry to the register of midwives and the standards for practice that all women's antenatal midwifery care includes a comprehensive booking visit, which includes assessment for modifiable risk factors. NZCOM is currently undertaking a review on the consensus statement *Assessment and Promotion of Baby Wellbeing During Pregnancy*, which includes a statement about booking assessment and referral. NZCOM's consensus statement *Sexually Transmitted Infections Screening* has just been updated. NZCOM notes that DHBs are addressing the issue of first trimester registration and inequities in access to first trimester care through the MQSP, on which local midwives are contributing members. **DHBs** – The majority of DHBs note the importance of early registration with an LMC, early mid-stream urine screening, sexually transmitted infection screening and referral to specialist care, including counselling at the time of a preterm birth. This counselling should outline strategies likely to be recommended for any future pregnancy. Capital & Coast DHB has systems in place around triaging of appointments and ensuring women come to clinic for appropriate investigations. Through MQSP, the four Northern Region DHBs (Auckland, Counties Manukau, Northland and Waitematā) are working in collaboration to develop written information that can be used to support education of women and their families about the risks, prevention, and management of preterm birth. They are investigating the possibility of a video to support this work. Other DHBs have noted interest in utilising these resources once available. Early registration with an LMC was an area highlighted by multiple DHBs. Canterbury and West Coast DHBs note their early registration rates to be over 78.1% – however, there is an ethnic disparity in early registration. This is noted as a key feature in the formation of their draft strategy. Nelson Marlborough DHB notes their early registration rate to be 89% of women booked in first trimester. Northland DHB reports success of

	their work on early engagement in pregnancy. Rates of first trimester registration in Northland DHB have increased from 47% to 66% in the last financial year – however, more work needs to be done in the Far North, which has not reflected this increase. Engagement barriers were highlighted in Tairāwhiti and Whanganui DHBs. Whanganui DHB has a severe shortage of community-based LMCs. In response, they have started a primary maternity care clinic run by a core midwife. A number of audits relating to preterm birth are underway in Hawke's Bay, Northland, Waitematā, Auckland and Counties Manukau DHBs. Hawke's Bay DHB has highlighted a need for a national approach to preterm birth.
3. Birth in a tertiary centre is associated with improved outcomes for preterm babies at the lower limits of viability (prior to 25 weeks' gestation). The PMMRC recommends the Ministry of Health leads the development of a national consensus pathway for the care of women in preterm labour or requiring delivery prior to 25 weeks' gestation. The PMMRC recommends this pathway includes: a. ensuring that all groups of women (irrespective of ethnicity, age, socioeconomic status or place of residence) are offered and provided the same level of care b. strategies for secondary units for management of women in threatened or early preterm labour, or who require delivery, prior to 25 weeks' gestation, including: i. administration of corticosteroids and magnesium sulphate ii. timely transfer from primary and secondary units to tertiary units iii. management of babies inadvertently born in their units at the lower limits of viability c. ensuring that priority populations have a voice in the development of health policy, process and practice in order to achieve equitable health outcomes d. guidance on monitoring that care provision is equitable by ethnicity, age,	As mentioned above, **the Ministry of Health** shares the PMMRC's desire to see progress in reducing preterm birth and reducing inequalities in the maternity system. One of the themes mentioned in the whole of maternity system action plan is 'strengthening commissioning and accountability; supporting quality and safety', with the MQSP being central to this theme alongside the PMMRC, the National Maternity Monitoring Group, the Health Quality & Safety Commission and the Health Research Council. Part of this work is the development of a quality assurance framework that includes the above and will oversee the planning and development of: • maternity related reports • clinical indicators • national consensus pathways and guidance/guidelines • the MQSP.

socioeconomic status and place of residence.	
4. The PMMRC recommends DHBs make available appropriate information, including appropriate counselling, for parents, families and whānau about birth outcomes prior to 25 weeks' gestation to enable shared decision-making and planning of active care or palliative care options.	The New Zealand Newborn Clinical Network has produced a New Zealand Consensus Statement on the Care of Mother and Baby(ies) at Periviable Gestations, which is about to be released. The following bodies have endorsed this consensus statement: • New Zealand Royal Australian College of Physicians • NZCOM • RANZCOG (formal letter is awaited) • Paediatric Society of New Zealand. This guideline standardises the care provided to mothers and babies. It includes parent information and decision aid for parents and families of babies likely to be born at 23–24 weeks' gestation. **DHBs** – Some DHBs report already using this draft consensus statement, while others have said they will adopt it once finalised. Capital & Coast DHB collaborates with different areas within the hospital to provide women with appropriate information, including Maternal Fetal Medicine Services, Neonatal Intensive Care Unit, the DHB Palliative Care Service (when required) and Te Māhoe Pregnancy Counselling Service inpatient staff and Sands (a support network for bereaved parents if required).
5. The PMMRC recommends that DHB maternity services audit the rates of antenatal corticosteroid administration, including repeat doses when indicated, to mothers of neonates live born at less than 34 weeks' gestation, including auditing whether administration is equitable by ethnicity, DHB of residence, and maternal age.	**DHBs** – Tairāwhiti, Hawke's Bay, Auckland and Waikato DHBs have undertaken an audit of the rates of antenatal corticosteroid administration. Waikato plans to do a further audit in 2019/20 to look at ethnicity, DHB of residence and maternal age. Hawke's Bay DHB reports that 48% of women completed steroids and another 30% started but did not complete. This was mainly due to the short timeframe from presentation of the labouring woman to the birth. Capital & Coast DHB has an audit in progress and Canterbury, West Coast, MidCentral and Hutt Valley DHBs all plan to audit in the 2019/20 financial year. Wairarapa DHB plans to be involved in a project auditing the use of corticosteroid administration and repeat doses through the MQSP. Taranaki DHB notes that they last audited antenatal corticosteroid administration in 2017.

	Northland, Hawke's Bay and Tairāwhiti DHBs have also recently updated their preterm birth guidelines.
6. The PMMRC recommends that tertiary obstetric and neonatal intensive care units investigate and address the difference between units in survival rates amongst infants born at 23–26 weeks' gestation as part of their benchmarking and quality and safety initiatives.	The Newborn Clinical Network is reviewing data on survival over three years (numbers are small, so annual rates fluctuate widely). This is based on feedback from the Australia and New Zealand Neonatal Network. This review includes survival of all babies born after 22 weeks' gestation but less than 32 weeks' gestation. The review involves multidisciplinary team discussions to assess risk factors and makes recommendations for future pregnanc(ies).
7. The PMMRC recommends that regulatory bodies require cultural competency training of all individuals working across all areas of the maternity and neonatal workforce. Training should address awareness of, and strategies to reduce and minimise the impact of, implicit bias and racism.	**RANZCOG** has introduced a mandatory component into the Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists training programme. This is an online and kanohi ki te kanohi (face to face) course called 'Application of the Hui Process/Meihana Model to Clinical Practice', which is facilitated by the Māori Indigenous Health Institute (MIHI), Otago University, Christchurch. Standards for doctors as part of the Medical Council of New Zealand statement on cultural competence will place a greater onus on all fellows to complete cultural competence and safety training like the MIHI course mentioned above. **NZCOM** – Although not a regulatory body, NZCOM has put significant focus on developing and providing continuing education in this area. Prior to the release of the PMMRC 12th annual report, NZCOM had initiated strategies to strengthen cultural consciousness within midwifery through the development and provision of the two new workshops for midwives nationally. The overarching aim of both workshops is to support an increased understanding and awareness of cultural consciousness within midwifery to benefit Māori and Pacifica women and whānau. The profession has welcomed the concept of raising cultural consciousness, which supports the development of cultural competency. The two workshops developed are: • Grounding Practice within Te Tiriti/the Treaty relationship (8-hour workshop unpacking the history of Aotearoa/New Zealand in order to

	understand how to be honourable partners in the Tiriti/Treaty relationship) • Birthing Across Cultures in Aotearoa/New Zealand (8-hour workshop for midwives to consider the inequities in health care outcomes and overall impact on health from a broader perspective).
8. The PMMRC recommends that the Ministry of Health and DHBs have a responsibility to ensure that midwifery staffing ratios and staffing acuity tools: a. enable active observation of mothers and babies who are undertaking skin-to-skin contact in the postnatal inpatient period b. allow for the identification of, and additional needs of, mothers who have increased risk factors for sudden unexpected death in infancy (SUDI).	**DHBs** – All DHBs have the Care Capacity Demand Management programme, which is a set of tools and processes that help DHBs better match the capacity to care with patient demand. Many DHBs also have Trendcare, a planning and workload management system. DHBs that use these include Hawke's Bay, Hutt Valley, Northland, Taranaki, Tairāwhiti, Lakes, Nelson Marlborough, Capital & Coast, Waikato and Canterbury. Capital & Coast DHB has recently participated in TrendC (acuity tool) timing studies to better reflect the maternity-specific environment. Wairarapa DHB uses LMC advanced booking to allow for opportunities to plan for periods of increased activity and have the flexibility to increase the staffing on a shift-by-shift basis. While some DHBs do not have a problem with staffing, many do. Hawke's Bay DHB notes that as per the national context the midwifery workforce is experiencing significant shortfalls, and this is a challenge for their DHB. Auckland and Lakes DHBs both also noted this challenge. Many DHBs have prioritised education for midwives, the mother and her family around safe sleeping and SUDI risk factors. This is due partly to the fact that while most often skin-to-skin time is supervised, there are times it is not and so education around safety is key. Hawke's Bay DHB noted that 90–100% of women have been screening for SUDI risk factors, and all women who smoke have been referred to a smoke-free incentive-based programme. Taranaki DHB has appointed a safe sleep, SUDI, smoking cessation coordinator in their DHB.
9. The PMMRC recommends that LMCs and DHBs ensure that every baby will have access to a safe sleep place on discharge from the hospital or birthing unit, or at home, that is their own place of sleep, on their back and with no pillow. If they do not have access to a safe	**RANZCOG** plans to discuss this at the upcoming Clinical Directors and Midwifery Leaders meeting. **NZCOM** has promoted the National SUDI Prevention Online Training to its members, which includes the mnemonic PEPE, which stands for:

sleep place, then a wahakura or Pēpi-Pod® must be made available for the baby's use prior to discharge from hospital.	• **P**lace to put the baby in their own bed: includes wahakura and Pēpi-Pods • **E**liminate smoking during pregnancy: midwives routinely refer for smoking cessation support • **P**osition baby on their back to sleep • **E**ncourage and support mum to breastfeed. **DHBs** are contracted by the Ministry of Health to distribute about 8,500 safe sleeping devices each year, including wahakura and Pēpi-Pods, with individual DHBs deciding which are most suitable for its population. In the 2018/19 period, Auckland DHB distributed 304 Pēpi-Pods. Many DHBs, including Canterbury, West Coast, Capital & Coast, Tairāwhiti and Hutt Valley, have wahakura for distribution. Canterbury, West Coast, MidCentral, Northland and Wairarapa DHBs also have wahakura weaving wānanga (educational seminars) available in their DHB region. Auckland, Taranaki, Nelson Marlborough, Canterbury, West Coast and Tairāwhiti DHBs have appointed a safe sleep coordinator. All DHBs mention education as an important factor in SUDI prevention. This includes education of health professionals and education of mothers. A number of DHBs have mentioned the SUDI online training that they have encouraged staff to complete. Educating the mother and her family on safe sleep is also noted as an important part of SUDI prevention. Northland DHB extends education to a number of people and organisations, including midwives, childbirth educators, iwi health providers, Family Start, and maternal and infant health and pregnancy and parenting services.