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Maternity Services Consumer Council

WELCOME, TENA KOUTOU KATOA, KIA ORANA, TALOFA LAVA, MALO LELEI, FAKAALOFA ATU.

Welcome to the fourth issue of the MSCCôs Newsletter for 2015. Since September we have launched our new leaflet, ñ*Choosing Where to Labour and Birth*,ò attended the Auckland and Waitemata DHB Maternity Collaboration workshop on 25 November, continued working towards a purpose-built maternity unit in West Auckland, and attended Waitemata and Auckland DHB meetings. Meanwhile, we continue to respond to requests for information, and mail out thousands of our leaflets.

Funding

The MSCC is very appreciative of the $3,771 we received from Pub Charity, the $5,200 we received from four of the five Auckland COGS committees, and the $30,000 we received from Lottery Community.

MSCC is seeking a new co-ordinator

After nearly 24 years working as the MSCCôs co-ordinator I, Lynda, will be leaving the MSCC at the beginning of 2016 as I have recently been diagnosed with cancer. The MSCC has been an important part of my life since I began working for the organisation in 1992. There have been major changes to both the health system and to the way maternity services are provided over the past 25 years, and the MSCC has had a significant part to play in providing a consumer perspective at first a local level and then nationally during some momentous changes. I am very appreciative of the support of all those who have been part of the MSCCôs Steering Group over these years. It has been challenging and intensely rewarding, and I feel incredibly privileged to have had such a wonderful job.

The MSCC will be advertising the MSCC co-ordinator position in the New Year. The role is a part-time one ï 20 hours per week ï with the potential to increase the hours as funding permits. Contact the MSCC on 520-5314 for further information.

What's in this issue of the newsletter

This issue of the newsletter features an update on delayed cord clamping, an update on the Waitemata DHB/Auckland DHB Maternity Services Collaboration, a promotion for the latest leaflet in our ñThe Factsò series, and a summary of some of the information in the Perinatal and Maternal Mortality Review Committee (PMMRC) Report for 2013.

DELAYED CORD CLAMPING STILL NOT ROUTINE

Despite mounting evidence of the harm done to babies as a result of early cord clamping, New Zealand obstetricians and far too many midwives are still clamping and cutting the umbilical cord almost immediately after birth. There is no, and never has been, any evidence to support the practice of clamping the cord before it has stopped pulsating. Before the mid-1950s most cord clamping and cutting happened when the umbilical cord stopped pulsating, around five minutes after birth. Cord clamping was originally introduced to reduce the risk of postpartum haemorrhaging, despite the lack of evidence of any relationship between early cord clamping and maternal bleeding. There is also no evidence to support a relationship between delayed cord clamping following a normal birth and hyperbilirubinaemia or jaundice.

While premature clamping and cutting of the cord was introduced and became routine practice without a shred of evidence that it would be safe to interfere with the natural process that ensures that babies get the blood they need to make the transition to life outside the womb and to stay healthy, changing back to what nature intended needs research studies and randomised controlled trials and a campaign to try and convince maternity care providers that it is safe to leave the cord until it has stopped pulsating. How sick is that!

In 2012 paediatrician Mark Sloan wrote: ñThough there is no strong scientific support for immediate cord clamping (ICC), entrenched medical habits can be glacially slow in changing.ò(1)

ñWhether a baby is premature or full term, approximately one-third of its total blood volume resides in the placenta. This is equal to the volume of blood that will be needed to fully perfuse the fetal lungs, liver, and kidneys at birth.

In addition to the benefits that come with adequate iron stores, babies whose cords are clamped at 2 to 3 minutes ï and thus, who have an increased total blood volume compared with their immediately-clamped peers ï have a smoother cardiopulmonary transition at birth.

A third benefit: stem cells, which play an essential role in the development of the immune, respiratory, cardiovascular, and central nervous systems, among many other functions. The concentration of stem cells in fetal blood is higher than at any other time of life. Immediate cord clamping leaves nearly one-third of these critical cells in the placenta.ò

Recent research has confirmed that babies are deprived of around a third of the vital blood they need from the placenta when the cord is clamped and cut early, and that this can be shown to be still affecting them months and even years later. Premature babies also benefit from delayed cord clamping.

Six months ago *JAMA Pediatrics* published the results of a study undertaken by researchers in Sweden which measured the effects of delayed cord clamping on children past infancy and up to four years of age, a time frame that few doctors have examined. (2) In the study, a group of 263 healthy Swedish full-term babies were randomly split into two groups. One group had their umbilical cords clamped less than 10 seconds after birth. The cords of the other group were clamped three minutes after birth. The two groups were then monitored for four years. The babies with delayed cord clamping performed modestly better on tests assessing their fine motor skills and social skills. The boys in the study displayed the most statistical improvement. The results, researchers say, showed no difference in overall IQ.

Lead researcher, Ola Andersson told CNN ñIt's incredible to see what a difference an extra three minutes and one-half cup of blood can have on the overall health of a child, especially four years later.ò(3)

The publication of this latest research follows publication of her previous study on the effect of premature cord clamping on the iron status of 4-month old babies which appeared in the *British Medical Journal* in 2011. (4) The study revealed that delayed cord clamping, compared with early clamping, resulted in improved iron status and reduced prevalence of neonatal anaemia which is associated with impaired development.

In June 2013 the MSCC's newsletter reported on the campaign in the UK to change the practice around cord clamping. Childbirth experts including midwives were urging the National Health Service (NHS) to reverse its policy on premature cord clamping and advocating for the National Institute for Health and Care Excellence (NICE) which advises the NHS to change its guidelines.

At that time Andrew Gallagher, a consultant paediatrician at the Worcestershire Royal Hospital in Worcester, which adopted delayed cord-clamping in 2009, said: "Immediate cord-clamping is a harmful practice because it denies the baby the blood from the placenta, and means that later on they are more likely to become iron-deficient. That matters because iron deficiency can cause serious problems. It affects the brain and learning capacity of toddlers ... [who] are going to be slower to learn, for example to speak and to understand. It's time for the NHS to sweep away an outdated and potentially harmful and thoughtless practice that we have been doing for decades,ò he said.

UK midwife Amanda Burleigh is another active and persistent campaigner who has spent the past decade campaigning on behalf of babies. Amanda was interviewed in April 2015 by the *Daily Mail* following the change to the NICE guidelines, (5) and was named Midwife of the Year by the *British Journal of Midwifery*. ñIn 20 or 30 years I think we will look back on immediately cord-clamping and think ñWhat were we doing? We dropped an absolute clanger,ò she said. Amanda is now supporting midwives all around the world to change their

practice around immediate cord clamping, including Australia, Norway, Sweden, Pakistan, Tunisia, Israel and Turkey.

In 2010 Amanda joined forces with a group of consultants let by Dr David Hutchon. Realising that one of the obstacles to delaying cord cutting was needing to take the baby away for resuscitation, they developed a trolley which is now known as Basics/Lifestart. ñTypically about 15% of babies need some form of resuscitation after birth (though a hospital audit suggested leaving the cord intact could reduce this to 5%). The Basics/Lifestart trolley is a small resuscitation unit that can be wheeled up to the bed and allows the cord to be left intact while the baby is resuscitated. Hospitals have started buying them so they can carry out the new evidence-based practice that babies should be attached to the cord for at least a minute after birth.ò(6)

Changing the practice around immediate cord clamping in New Zealand has also been underway for some time. In August 2013 the NZ College of Midwives revised their consensus statement on facilitating the birth of the placenta. As part of what they refer to as ñphysiological placental birthò, also known as physiological third stage, the statement recommends that ñthe cord is left alone until either it stops pulsating, or preferably, the placenta is born so the baby receives an optimal blood supply to start extra-uterine life, the cord may then be clamped/tied and cut.ò(7)

In August 2014 the Canterbury DHB issued their own guideline on umbilical cord clamping for babies at or near term. It begins by stating that: ñthe question of when to clamp the umbilical cord after birth has received renewed attention in recent years. Compelling evidence has been published supporting the practice of waiting for placental perfusion which aids the newborn's physiological transition to extra-uterine life.ò(8)

Delayed cord clamping is usually considered to be part of a physiological third stage which includes not using drugs to hasten the birth of the placenta, and not pulling on the umbilical cord (controlled cord traction) after the baby is born, as well as leaving the cord intact until it has stopped pulsating.

However, in Auckland, in their latest Annual Clinical Report, National Womenôs defines physiological third stage as ñexpectant management without ecbolic and delivery of the placenta by maternal effort.ò There is no mention of waiting until the cord has stopped pulsating before clamping and cutting it as part of their definition.

The latest Annual Clinical Report also records that ñin 2014 rates of physiological management of the third stage are unchanged.ò The previous yearôs report states ñin 2013 the management of the third stage of labour has changed insignificantly from 2012. Physiological management of the third stage remain unchanged.ò

By excluding ñthe practice of delayed cord clampingò as part of a physiological third stage which the latest report states has increased but doesnôt say by how much, the true picture of what is happening to babies at National Womenôs immediately after birth remains hidden.

Middlemore hospital on the other hand introduced delayed cord clamping as standard practice in 2010. However, it is still an issue for very premature babies as a recent research proposal that came before the Northern A ethics committee in October revealed. The study is called the ABC Study and is an attempt to prevent morbidity and the need for blood transfusion by delaying clamping of the cord in babies who are less than 31 weeks gestation. The study will investigate whether delayed cord clamping and breathing assistance can improve the short and long term outcomes for very preterm babies.

During the lengthy discussion on this proposal the researcher stated that delayed cord clamping is not standard treatment in New Zealand for preterm babies, and is still only standard treatment for term babies in some hospitals. After the introduction of delayed cord clamping as standard practice in 2010 researchers at Middlemore hospital compared babies over 31 weeks gestation who did not have delayed cord clamping with those who did, and found there were better outcomes for the babies when the cord was not clamped immediately after birth. And now they are trying to prove that there would also be better outcomes for very premature babies who have delayed cord clamping. Isnôt this common sense? It shouldnôt require any more research trials to return to a practice that we now know is best for all babies.

The next step is to require all DHBs to record the percentage and numbers of babies who are given the gold standard of immediate postpartum care by leaving the cord to stop pulsating before it is clamped and cut.

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AUCKLAND DHB and WAITEMATA DHB COLLABORATION MATERNITY PLAN

At the end of November the MSCC received a copy of the ñ*Auckland DHB and Waitemata DHB Collaboration Maternity Plan: Working together to plan future maternity services to 2025*ò along with notification of a 2-hour meeting scheduled for 10am on 25 November 2015. It was not clear whether the document was the consultation document we had been promised in January, and had been waiting months for, or something prepared for the meeting. Given the document did not contain options for the community to consider or call for submissions by a due date, the MSCC decided it was a document prepared for the meeting.

The document stated that the Collaboration Steering Group had identified five broad issues they wished to address:

- Inequalities in health outcomes
- Fragmented care
- Inconsistency in the models of care
- Quality and safety issues
- Facility issues

ñIn order to address these issues we have developed 22 strategies to build a high quality sustainable maternity service across our two DHBs, through changes to maternity facilities, and current care delivery models.ò The strategies were grouped into six themes:

- Achieve equity
- Enhance maternity quality and safety
- Enhance continuity of care
- Strengthen confidence in normal birth
- Support transition to parenthood and infant attachment
- Ensure facilities meet population needs, including capacity for future growth

The document regurgitated a lot of ñinformationò on issues that maternity community groups were discussing decades ago, and referred to the stakeholder engagement in the plan development. Among the consumer organisations listed on page 43 is Playcentre, but there is no mention of Parents Centre, the oldest childbirth and parenting organisation in New Zealand.

Those who turned up at the meeting found themselves having to choose one of the themes and go to the table assigned to that theme. This was a repeat of what occurred at the January meeting. It is a great way to control and direct the ñconsultationò process and limit the input of those who come to these meetings.

Some of those who turned up had done so in order to discuss the issue of primary birthing units as outlined in Strategy 22 ï ñIncrease the number of primary birthing beds across the region. Engage in broad public and stakeholder consultation to ensure the type and location of primary birthing unit best meets the needs of the communities served by the DHBs,ò but it was made clear during the initial DHB presentations that this was not on the agenda for this meeting.

Once the DHB talk fest was completed each table was charged with choosing the make-up of the multi-disciplinary working or stakeholder groups that the Collaboration Steering Group had decided upon. The meeting was told that each group must contain at least one of four ñvoicesò ï the voices of intent, design, experience, and expertise ï that the DHBs decided were needed.

Then each person was given 5 purple dots to stick on one of two charts on the wall, and sticky notes with our comments written on them to stick on other sheets of paper also stuck to the wall.

This ñconsultationò meeting was extremely frustrating and an utter waste of time for those who attended the meeting to discuss other issues about the future of maternity services in the two DHBs. It limited input to only those topics that the DHB were prepared to seek suggestions on, and ensured that nobody got to discuss the issues of importance to them.

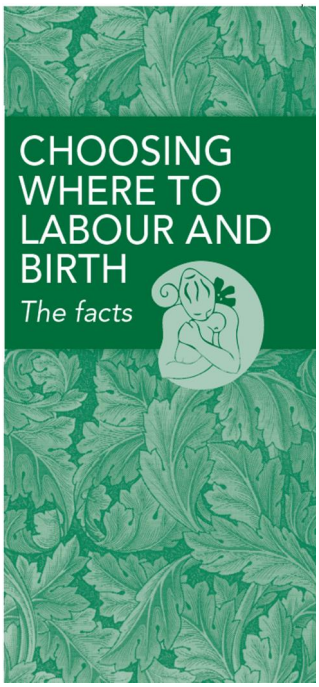
When ñconsultationò meetings are organised in a way that is so tightly controlled and limits discussion to only those subjects that the DHBs are prepared to put on the agenda, then questions need to be asked about the integrity, transparency and accountability of the DHBs to the communities they purport to serve.

The day after the meeting the MSCC received a follow-up email from the DHBs. The email stated that: ñwe would like to ensure that maternity and community stakeholders in the Auckland DHB and Waitemata DHB are included in the conversations around these strategies. We invite you to participate in this Collaboration Maternity Plan by:

1. Providing feedback
2. Expressing interest, if you wish to be involved in the working or stakeholder groups,
3. Providing a view on relative priority for the pieces of work that we have outlined, as not all of the work will be possible to progress immediately.ò

So there is little hope of there being any change in this incredibly controlled ñconsultationò process in the foreseeable future.

CHOOSING WHERE TO LABOUR AND BIRTH



The MSCC has produced a seventh leaflet in its "The Facts" series.

ñ*Choosing where to Labour and Birth*ò provides women with evidence-based information on how the place of birth can impact on labour and birth, as well as the future health and well-being of both the mother and the baby. It describes the importance of having access to safe birthing environments that support the hormonal and physiological processes of labour and birth. It details the important hormones of labour and birth, outlines the events which often disturb the cocktail of hormones, and lists the interventions that contribute to this. It also describes how to create a supportive birth space.

There is a charge for all the leaflets in ñ*The Facts*ò series.
An order form for all our leaflets is available on the MSCC website: http://www.maternity.org.nz/what-we-offer/

PERINATAL & MATERNAL MORTALITY IN 2013

The Perinatal and Maternal Mortality Review Committee (PMMRC) recently released its report on perinatal and maternal mortality in New Zealand for the year 2013. This is the committeeôs ninth PMMR report. This year the report includes data on babies who died in New Zealand between 2007 and 2013, and mothers who died from 2006 to 2013.

Maternal mortality in 2013
There were five direct maternal deaths, and six 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 five direct maternal deaths were two as a result of sepsis and two as a result of amniotic fluid embolism and one as a result of an ectopic pregnancy. The six indirect deaths included two suicides, two mothers with pre-existing medical conditions, one from sepsis and one mother who suffered an intracranial haemorrhage.

Eight years of data
The 89 direct and indirect maternal deaths from 2006-2013 included:

- 31 antepartum and 58 postpartum
- 57 occurred in hospital and 32 in the community
- 23 mothers died prior to 20 weeks gestation, and 66 died at or after 20 weeks
- 32 with potentially avoidable factors present, 53 with none and four were unknown.

Pre-existing medical disease, suicide and amniotic fluid embolism (AFE) were the most frequent causes of maternal mortality in New Zealand in 2006 ï 2013. AFE is the cause of 40% of direct maternal deaths in New Zealand.

Suicide
Of the 54 indirect maternal deaths during this eight-year period 21 were the result of suicide.

Potentially avoidable deaths
The report notes that in the seven years from 2006-2013 the MMR working group believed that 36% 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, barriers to access and or

engagement with care in around a third of cases overall, but barriers were less often identified among direct deaths than among indirect.

Organisational problems

The major factors involved in the potentially avoidable deaths included 21 cases relating to lack of policies, protocols or guidelines, 13 relating to inadequate systems/ process for sharing of clinical information between services, 11 relating to inadequate education and training, six relating to poor organisational arrangements of staff, four relating to a failure or delay in the emergency response, three relating to poor access to senior clinical staff, and two to a delay in procedure, eg caesarean section.

Clinical characteristics

Over the years 2006-2013 approximately 25% of mothers who died were having their first baby, while a further 25% had had more than four prior births. Nearly 60% of the mothers were overweight or obese. The report also reveals that just over a third of mothers were current smokers.

Perinatal mortality

In 2013 there was a total of 598 perinatal related deaths ï 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 181 perinatal related deaths caused by lethal and terminated foetal abnormalities brings the total of deaths down to 436.

PMMRC chairperson, Sue Belgrave, noted that spontaneous preterm births are the second highest cause of perinatal death in New Zealand was a special focus of this yearôs report.

The rate of babies dying from 20 weeks of pregnancy to 28 days has fallen to the lowest number since reporting began in New Zealand in 2007. The overall reduction in perinatal mortality included a significant reduction in stillbirths at term ï from 117 in 2007 to 69 in 2013.

The report reveals that women who smoke in pregnancy, who have a BMI of over 25, live in areas of high socioeconomic deprivation and who are of Maori, Pacific and Indian ethnicity are more at risk of losing a baby.

The PMMRC found that the following district health board (DHB) areas have significantly higher unadjusted rates of perinatal related death than the New Zealand rate and may require additional assistance to address these issues:

- Counties Manukau ï all perinatal related mortality
- Northland ï stillbirth and neonatal death rate
- Bay of Plenty ï neonatal death rate.

Recommendations

This yearôs report includes two recommendations relating to maternal mortality:

- Seasonal or pandemic influenza vaccination is recommended for all pregnant women regardless of gestation, and for women planning to be pregnant during the influenza season.

- All women with epilepsy on medication should be referred to a physician.

The PMMRC report can be found at:
http://www.hqsc.govt.nz/publications-and-resources/publication/2123/

MSCC Meeting Dates for 2016

Our MSCC Steering Group is growing and this can only mean great things for the women of New Zealand. Make sure your voice is heard - please make a note of the following dates for the coming year in your diary and come along to our monthly meetings. You can be assured of a warm welcome.

The MSCC meets at 10am on Tuesday mornings ï and the days have been fitted around school holidays.

The Steering Group meetings are held at Birthcare in Parnell. The meeting dates for the first half of 2016 are:

2 February, 1 March, 5 April, 3 May and 7 June 2016

So if you have an issue of concern or would like to share information about womenôs experiences of maternity care then do come along. Babies and toddlers welcome.