MATERNITY, MIDWIFERY AND BABY FORUM SEMINAR ABSTRACTS

SEMINAR 1: NHS Ayrshire and Arran: Vulnerable Families Maternity Team

Elaine Moore
Clinical Midwifery Manager In-Patient/Outpatient Services
Ayrshire Maternity Unit

This service has improved the experience of women with complex social needs by providing consistency of approach, continuity of care and carer during pregnancy and the postnatal period. It has improved communication between the wider multi-agency team ensuring that information sharing is consistent and of a high standard. There is a more immediate response for families experiencing difficulties to help reduce the number in crisis. Multi-agency working during pregnancy has improved to ensure that there is a robust risk assessment for families identifying needs and ensuring that unborn babies are protected. The service also works more effectively with fathers to ensure they are involved in the delivery of care for their partners and unborn infants.

The VF team works closely with NHS and Social Services addiction teams to individualise care plans for pregnant women who have addictions. The aim is to support women, reduce fetal dependency and admission to the Neonatal unit with neonatal abstinence syndrome. They also work closely with Neonatal staff to prepare parents and foster carers for the reality of caring for babies with differing degrees of neonatal abstinence syndrome.

This has allowed for the formulation of individualised care packages for families deemed at risk. These families are involved in the conception and continuation of their care packages ensuring improved support for parents, improvements in bonding and infant mental health.

Recent figures from the North Ayrshire Vulnerable Families reflect an increasing trend in referral to and involvement of the Vulnerable Families Midwifery Team, with a correlating decrease in the number of babies undergoing a CPO. This would suggest that the team through multiagency working is reducing the numbers of babies being removed at birth from their parents.

SEMINAR 2: I AM CMV

Sharon Wood
Project Manager
CMV Action

I have infected 3 out of 5 people you will ever meet.

Yet most don't even know that I am there.

In most people I probably won't have caused anything more than a mild sniffle before I hide, unnoticed forever.

Yet, to an unborn baby I can cause serious harm.

I can cause miscarriages. I can cause stillbirths.

2 or 3 babies are born every single day in the UK who have been affected by me.

That's nearly 1,000 every year.

These babies can have hearing and vision loss, cerebral palsy and epilepsy.

Currently you cannot vaccinate against me and in the UK nobody screens for me.

So you can't stop me.

But with greater awareness, I can be outsmarted.

The more people talk, the more they will know how to reduce the risk of exposure to me.

The more they know, the more they can identify the babies I have affected.

But until you realise how vulnerable I really am, I am the stealth virus.

Around 1 in 5 babies born with cytomegalovirus (CMV) will suffer serious consequences. Not only does this put a huge strain on the families affected, but also on the NHS.

Currently pregnant women receive no advice about reducing their risk of infection. Educating them, as well as healthcare professionals, is fundamental to winning the fight against CMV.

The main way that pregnant women catch CMV is from the urine and saliva of small children. There is a growing body of research that shows that providing pregnant women with this information can reduce the risk of acquiring CMV in pregnancy. We know that pregnant women are highly motivated to follow preventative advice and that British women of childbearing age want to know more about CMV.

CMV Action campaigns to raise this awareness.

SEMINAR 3: OBSTRACT and the art of delivery: how to avoid trauma to the pelvic floor

Dr Gloria Esegbona
OBGYN, Midwife
Winston Churchill Fellow 2015
Kings College Learning Institute

Obstetric trauma is increasingly being recognized to encompass more than just third degree tears. Damage to the levator ani occurs frequently after childbirth and sets up mothers for the sequelae later in life of prolapse, incontinence and sexual dysfunction.

Participants will be introduced to the innovative OBSTRACT system spawned during research at the University of Sydney, which aims to bring scientific and artistic clarity to the way the obstetric tract is perceived in clinical practice. They will be shown scientific evidence of the 3 main types of damage caused and for the first time how to prevent them with 3 women centred birth practices.

SEMINAR 4: iBumps' teenage pregnancy service

Elizabeth Bailey, Midwife Research Fellow,UHCW/Coventry University
UHCW: Women & Childrens Dept
Sam Nightingale and Tracy Standbridge-Boyle, Teenage Pregnancy Specialist Midwives,
UHCW NHS Trust/Coventry City Council

Coventry is a Marmot city and as such has recognised deprivation and health inequalities, and the teenage pregnancy rate in Coventry is consistently higher than the national average. The 'iBumps' service was specifically modelled to provide an innovative, co-ordinated, and seamless midwifery-led approach to the transition to parenthood. Led by Teenage Pregnancy Midwives, Sam and Tracy, the service aims to support young people with an individualised approach

through pregnancy and early parenthood. The iBumps service was developed to support those who needed support and were not eligible for the Family Nurse Practitioner (FNP) programme.

Young people referred to our service often have other significant complex needs and the continuity through communication of all agencies and support teams facilitated by iBumps means that these young families have all available support for the best start of their new lives together. This includes working closely with community midwives, health visitors, children centres, social care, sexual health and FNP. This is the first time Coventry has implemented this approach for teenage parents and so far it has been effective in supporting over 200 parents.

The iBumps model may benefit other areas where young people fall outside of the support offered by the family-nurse partnership and support community midwifery by complementing existing antenatal care. We plan to further evaluate the work of the iBumps service and disseminate our findings. Long-term the impact of the project will be evident through measurable outcomes and city statistics but short-term it is having an immediate impact with young person's relationships with midwives and healthcare. For now we rely on feedback and parents have talked enthusiastically about the services they have received:

'I would definitely recommend the service especially to other young people, I really do wish I has been offered iBumps while I was pregnant with my first child'

Please view our Youtube clip (link below) from Coventry City Council's video report *'Exceeding Expectations: Tapping into the city's future aspirations, hopes and ambitions for its children and young people*' 2015

http://www.tubechop.com/watch/7158886

SEMINAR 6: What do midwives want in an online intervention designed to support them in work-related psychological distress? Results from a Delphi Study

Sally Pezaro
Doctoral Researcher
Coventry University

Background
Midwives suffer in psychological distress (Pezaro, Clyne, Turner, Fulton, & Gerada, 2015). This is not compatible with safe, high quality care. Currently there is a lack of support for midwives, who often find it impossible to speak out, despite not feeling well enough to perform their clinical duties effectively. In response to this, new research explores the possibility of creating an online intervention designed to support midwives in work-related psychological distress.

Methods
A Delphi study was conducted. 185 experts were asked to provide their opinion upon what should be prioritised within an online intervention designed to support midwives in work-related psychological distress. 66 experts gave their responses through 2 rounds of questioning.

Results
Of the 20 questions posed, 11 lines of enquiry achieved a consensus of opinion and 9 did not. 900 free text responses were also provided by the expert panel. This generated 300 separate themes, categorised by two researchers. Early results show that both confidentiality and anonymity were found to be high priorities within the development of an online intervention designed to support midwives in work-related psychological distress, yet their corollary, amnesty was a source of tension. The expert panel also prioritised prompted help seeking, mobile compatibility and multimedia resources within this design.

Conclusions
Satisfying concerns in relation to the risk of harm to third parties by midwives; both preventing future harm and accountability for harm that has already occurred will be essential to the acceptance of an online resource for midwives experiencing work-related psychological distress. The principal challenge will be to balance the safety of midwives and the public, where the provision for regulating such an online intervention remains complex.

SEMINAR 7: Supporting vulnerable families

Jillian (Jilly) Ireland
Community Midwife, Supervisor of Midwives, RCM Union Learning Rep
Poole NHS Hospitals Foundation Trust

Early bonding and optimal parenting are important to promote safe and loving care between mothers and their children. The project has been set up by the midwife, health visiting and Children's Centre teams to meet the specific needs of this group of mothers. The setting in Poole (Dorset) is an area containing the highest number of children under 'child protection' orders in the borough.

We have co-created a creative and dynamic programme of activities to help women find their own ways of optimising preparation for birth and parenting. Involving people in their own care shows what matters most to them and engenders ownership and potentially, group leadership.

Each session starts with 30 minutes of elements from the traditional NHS antenatal class carrying on into a shared lunch. After lunch we offer an hour and a half of creative activity (e.g. singing, knitting, dance, hypnobirthing, craft activities, belly casting).

We draw from research evidence and the NICE guideline that antenatal education should be participant led NICE (2012). We use the engagement of participants and facilitators to foster confidence in coping with emotions in labour and early parenting, raise self-esteem and draw on support from peers in the group. We know, from neuroscientific research that children gather memories from their earliest years, including their months within the womb.

Singing and creative activities evoke hormonal responses which promote calm and help babies to develop into secure adults who can manage their emotions (and behaviours) in a way which helps them socially and educationally (Ireland & Oakland 2013).

The group has been running for seven months; early evaluation is positive. Group members are facilitating some sessions.

References
Ireland, J. and Oakland, J (2013) The old, old story – through song. Essentially Midirs. 4(9): 17-22.
NICE (2012). Antenatal care for uncomplicated pregnancies, London: NICE.

SEMINAR 8: A student reflection on dignity in midwifery care

Ilana Pizer Mason
Student midwife (year 3)
Middlesex University/Whittington Hospital

For direct entry student midwives 'out of midwifery' placement provides an invaluable opportunity to deepen understanding of care practices in other disciplines. I propose to present a reflective account of how my experiences during this period have taught me invaluable lessons of care, compassion and the importance of upholding dignity. Dignity is inherent to all people and forms the foundation of international human rights law. Those in our care are all vulnerable to some

extent, whether physically (e.g. in labour), emotionally, or socially and by ensuring every effort is made to consider the client's best interests and avoid harm wherever possible respects their dignity. This subsequently defends a woman's autonomy, facilitating independent decision making and a sense of control over her own care. I will relate this to the new NMC Code of Conduct and draw upon emerging research on the topic of dignity in maternity care – what it really means, the importance of reflection, and how we can implement small changes to keep dignity central to our work, helping women to trust us with their care, despite external pressures and busy workloads.

North Ayrshire Vulnerable Families				
	2011-2012	2012-2013	2013-2014	2014-2015
Referrals	96	149 Increase of 64%	145 Similar	150 Similar
Unborn babies on Child Protection register	28	47 Increase of 59%	35 Decrease of 24%	34 Similar
Child Protection Orders and removal of babies at Birth	55	19 Decrease of 34 %	7 Decrease of 36 % (total decrease of 87% since the service began)	7 No change
Number of babies discharged home with full multi-agency supports in place	Not recorded	Not recorded	Not Recorded	27

SEMINAR 9: Nutrition in the first 1000 days and the impact on long term health

Maude Grant, Medical Communications Manager, Nestle Nutrition UK

Latest research showing how and why varying infant feeding methods can have an impact on later health outcomes and consequences.

Latest developments in the role of protein in early growth including why the protein quantity and quality in formula is being redressed.

SEMINAR 9L: Healthy backs for midwives

Harbir Singh, Osteopath & Lead Patient Handling Advisor, Homerton University Hospitals

Musculoskeletal disorders are the number one cause of long term sickness absence in Midwives. This presentation will impart the skills and techniques needs to maintain a health back throughout your midwifey carer. The presentation consists of specific exercises, movements and postures designed for Midwifes, to relieve and prevent musculoskeletal disorders including back pain.

SEMINAR 10: Pilot of a cluster randomised controlled trial of community midwifery training – a psychological approach for preventing perinatal depression

Julia Austin, Consultant Midwife
Molly Patterson, Research Midwife
Traolach [Terry] Brugha, Professor of Psychiatry and Director of Research
University Hospitals of Leicester Trust

This project is a pilot randomized controlled trial and it examines the unique and influential relationship between women and midwives and how that relationship can be used to improve public health outcomes.

Can midwives prevent antenatal depression by the way they look after the women in their care?

The midwives in the study were trained by psychologists in how to develop and culture a therapeutic relationship and how to use e a cognitive behavioral approach (CBA) and to care delivery . Women were then randomized onto care with an intervention midwife or a control group midwife.

- Three hundred women and 16 midwives took part in the study
- All women recruited self- assessed using Edinburgh depression scale (EDS), at baseline around 12 weeks gestation**.**
- Intervention midwives administered face to face EDS assessment at 15-20 weeks gestation. Positive EDS were repeated at 17-22 weeks. If EDS positive twice CMW offered at least 3 CBA sessions.
- Primary follow up questionnaire was at 34 weeks gestation.

Main outcome measures: Comparison of baseline EDS to the 34/40 EDS to both intervention and control groups.

Results

Women in intervention group were less likely to get depression. There was a 7% difference between the control and intervention group

SEMINAR 11: 24 hour labour line: Rethinking telephone support for women during early labour

Marie Nott
Midwifery Lecturer
University of Southampton
Acknowledgements**:** Dr Ellen Kitson-Reynolds and Dr Nicola Jarrett

Due to the relationship between admission during the latent phase of labour and the risk of intervention during established labour (Holmes et al 2001; Bailit et al 2005; Lundgren et al 2013) women are advised to remain at home, during the latent phase of labour (National Institute of Health and Care Excellence 2014). As such, National Health Service (NHS) Trusts in the United Kingdom must consider innovative ways to support women and their birth partners during this uncertain time (Cheyne et al. 2007; Nolan and Smith 2010). In 2013 Hampshire Hospitals NHS Foundation Trust (HHFT) implemented the '24 hour labour line' (LL), a dedicated, midwife-led telephone support line for women and their birth partners to contact during labour.

The service is unique as it is based off site, in the local emergency operations centre, and the midwife's only role is provide advice, information and support to women at home during labour,

enabling the Royal College of Midwives recommendation that women have *'good access to verbal support and encouragement'* (White et al. 2012 pg 6) to be met.

An initial service evaluation completed by HHFT (MacKenzie 2014) identified a potential relationship between the implementation of the service and a reduction in the number of women admitted during the latent phase of labour. Furthermore, a survey of women and midwives experiences found that women and staff highly rated the service. Although this initial data and anecdotal feedback suggests that the service has a positive impact on women's experiences during the latent phase of labour, further exploration is required.
This presentation, by a doctoral student and LL midwife, will outline the implementation of the service, initial service evaluation data and the current research protocol exploring women, birth partners and midwives experience of the service.

References

Bailit JL, Dierker L, Blanchard MH and Mercer BM (2005) Outcomes of women presenting in active versus latent phase of spontaneous labor. Obstetrics and Gynecology 105(1): 77-79

Cheyne H, Terry R, Niven C, Dowding D, Hundley V and Mcnamee P (2007) 'Should I come in now?': a study of women's early labour experiences. British Journal of Midwifery 15(10): 604-609

Holmes P, Oppenheimer LW and Wu Wen S (2001) The relationship between cervical dilatation at initial presentation in labour and subsequent intervention. BJOG 108(11): 1120-1124

Lundgren I, Andrén K, Nissen E and Berg M (2013) Care seeking during the latent phase of labour – Frequencies and birth outcomes in two delivery wards in Sweden. Sexual and Reproductive Healthcare 4(4): 141-146

MacKenzie J (2014) *24hour labour line pilot in partnership with South Central Ambulance Service. Service Evaluation*. Hampshire Hospitals NHS Foundation Trust

National Institute for Health and Care Excellence (2014) *Intrapartum care for healthy women and babies.* London: National Institute for Health and Care Excellence.

SEMINAR 12: 'Eyes without sparkle - a journey through postnatal illness pregnancy after perinatal mental illness

Elaine Hanzak
Author

The need for additional awareness and support for parents who contemplate another baby after a perinatal mental illness

Why is this important?

The effects of maternal mental illness are well documented to have effects on the mother; her child (before and after birth; existing children; partner; relationships and employment. We currently spend 5 times more in treatment than we need to by preventative methods. Women have a 50% greater change of having perinatal mental illness again if they suffered before. Therefore for both personal and economic reasons it makes sense to help.

How can we help?

I would outline some of the key areas that healthcare professionals and parents can consider 'next time around'. This would include, for example, dealing with the past; relationship with the partner; pregnancy wellness; a different birth experience; choice of feeding; self-help techniques.

I would also outline some of the most important ways that parents have told me that HCPs can be most effective in this matter.

SEMINAR 13: Working in a low resource practice

Claire Reading
Midwife (five years qualified in Feb 2016)

I wanted to share my experiences of working as a midwife in the Democratic Republic of Congo for nine months of 2015; of being faced with situations I had only read about in textbooks. Of teamwork. Of patience. Of working and living in a country where English is hardly spoken.

My role was not to deliver babies or give hands on care, but to support the Congolese staff to increase their skills and knowledge, to train and supervise them in a practical way and for them to understand when it's time to call for help.

Midwifery practice in rural central Africa is full of joys (an abundance of twins, births by candlelight and resilience and stoicism that would leave even the very experienced birth practitioner speechless) but also a lot challenges (every obstetric emergency in your wildest nightmare and worse) that are compounded by a lack of access to a skilled birth attendants. Women here have a strong culture of traditional practices and remedies and hospital is often not the first port of call. Caring for women who cannot consent themselves for emergency, life-saving caesarean sections is a cultural aspect that we accept and respect as medical professionals working in DRC.

In a busy maternity ward in a low-resource setting in a hospital supported by emergency humanitarian medical organisation, Medècins Sans Frontiéres just how are obstetric emergencies managed and are the outcomes what you would expect? That is what the question I would like to explore in my presentation.

SEMINAR 15: Snuggle Bundle

Pamela Higgins
Maternity Quality Improvement Collaborative Lead
Ninewells Hospital

Over a 12 month period we had 18 babies separated from their mother by admittance to NICU. These possibly could have been avoided had risk factors been identified early and acted on appropriately.

In response to this and in collaboration with neonatal colleagues the Snuggle Bundle was developed.

The Snuggle Bundle is a safety bundle that aims to reduce the unnecessary separation of mums and babies by missed risk factors such as hypothermia, hypoglycaemia and/or infection.

It comprises of 3 main elements. 1: All babies' temperature is maintained.
2: Uninterrupted skin to skin
3: Risk assessed.

Not only does this safety bundle attempt to reduce physical and emotional hardships experienced with mother and infant separation, it also incorporates global values and recommendations set out by UNICEF in offering all babies skin to skin.
It encompasses patient safety measures targeted in Maternity and children's quality improvement collaborative (Mcqic) Neonatal measurement plan UDP2 – The at risk infant being cared for

using appropriate care pathway. As well as the Mcqic Maternity Care measure plan MB01 – Newborn babies who are normothermic at point of leaving birth area.

It has also motivated multidisciplinary working, teaching and sharing spheres of knowledge. It conjunction with the infant feeding team it has led to the purchase of 50 snuggy wraps to facilitate women who wish skin to skin with their baby in the postnatal period for as long as they desire.

In its first week of launch the snuggle bundle face to face educational sessions as well as the demonstration for correct application of the snuggy wraps were given to over 90 people from various professional disciplines. An electronic copy of the snuggle bundle learning presentation was sent to all midwives.

Although in its infancy it is proven that multidisciplinary collaboration leads to better effective quality care for women and their families.