Maternity, Midwifery and Baby 2016

Abstract Submissions

SEMINAR 2
Evidence for everyday midwifery: bringing research and practice together though social media

Speaker: Sarah Chapman, Knowledge Broker, Cochrane UK

Background

Our research organization produces high quality systematic reviews with the aim of informing decisions about healthcare, to positively impact health. Many of them are relevant for midwives, but they can be difficult and time-consuming to find and read.

Aims

We have developed successful and innovative ways to share evidence via social media. Having engaged with midwives on Twitter and heard that our blogs were being used in teaching, we wanted to do more to put relevant evidence into the hands of midwives with the aim of promoting best practice. We also wanted to encourage engagement with midwives and invite them to share their expertise, enabling our research to be considered in the context of everyday midwifery practice.

Design

In November 2015 we launched a new social media series, to be ongoing, Evidence for Everyday Midwifery (#EEMidwifery). We formed a partnership with a midwifery journal and our work together will include co-writing four articles in 2016, to be published in the journal and on our blog. The series largely comprises blogs and blogshots – mini infographics, focusing on new evidence relevant to midwifery practice. These are shared on a range of social media platforms. We have had a very successful tweetchat as part of our parallel series for nurses and this is something we plan to do with Evidence for Everyday Midwifery.

Evaluation

To evaluate the success of the series we are looking at three things: analytics, responses or conversations on social media and relationships built through this work. The initial response to the series launch was very positive and we will be evaluating each of the three areas in May, six months after the launch. We will also consider how to reach a wider audience of midwives.

SEMINAR 3
QUIPP: a tool to assist clinicians in the assessment of pregnant women at risk of preterm birth

Speaker: Jenny Carter, NIHR Clinical Academic Training Fellow/Research Midwife Division of Women's Health King's College London; Women's Health Academic Centre, KHP

Authors: Jenny Carter, Katy Kuhrt, Paul Seed, Andrew Shennan

Despite our best efforts in research and clinical practice, preterm birth remains a major cause of morbidity and infant death *(*Howson *et al.,* 2012*;* Marlow *et al.,* 2014*)*. Affecting around 7% of UK pregnancies annually *(*ONS, 2014*;* ISD, 2014*)* its consequences include substantial emotional and financial costs to families, as well as social and health care *(*Mangham *et al.,* 2009*).* Well-timed interventions, such as hospitalisation and steroid drugs to improve the baby's lung function, can reduce associated risks, but because the consequences of not intervening appropriately could be devastating, overtreatment is common. Negative effects of, potentially unnecessary, treatments include lower birth weights, poor maternal blood sugar control and blocked antenatal beds and neonatal cots which are then unavailable for women and babies who really need them.

In order to address this problem, we have developed the QUIPP app. This easy-to-use mobile application combines women's background risk with the two most promising predictors of preterm birth (cervical length and quantitative fetal fibronectin vaginal swab test). The app can be used in the care of pregnant women already known to be at risk (e.g. history of previous preterm birth), and those with no known risk, but with symptoms of threatened preterm labour. When risk factors and test results are entered, the tool instantly provides an individualised % risk of preterm birth

within clinically important time points, e.g. 7 days, 14 days, before 34 weeks' gestation. This assists clinicians and women in their management decisions and choices.

The predictive model is highly accurate (Kuhrt *et al*., 2015), permitting safe hospital discharge for the majority, and improved detection of those likely to deliver early. The data used in the development of the algorithm was collected at our award-winning Preterm Surveillance Clinic and as part of our on-going research programme (e.g. Abbott *et al*., 2015).

References

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SEMINAR 4
Why do some women choose to freebirth in the UK? An interpretative phenomenological study

Speaker: Claire Feeley, RM, BSc (Hons), MSc, PhD student**,** Midwife**,** Milton Keynes University Hospital/University of Central Lancashire

Author: Dr Gill Thomson, Senior Research Fellow, University of Central Lancashire

Publication: Feeley, C and Thomson, G. Why do some women choose to freebirth in the UK? An interpretative phenomenological study. BMC Pregnancy and Childbirth, 2016; 16(59) Open Access http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0847-6

Background: Freebirthing or unassisted birth is the active choice made by a woman to birth without a trained professional present, even where there is access to maternity provision. This has potential morbidity and mortality risks for mother and baby. While a number of studies have explored women's freebirth experiences, there has been no research undertaken in the UK.

Objective: To explore and identify what influenced women's decision to freebirth in a UK context.

Method: Advertisements were posted on freebirth websites September 2014. Ten women participated in the study, narrative (n = 9) and/or an in-depth interview (n = 10). Data analysis was carried out using interpretative methods informed by Heidegger and Gadamer's hermeneutic phenomenological concepts.

Key Findings: Three main themes emerged from the data. *Contextualising herstory* describes how the participants' backgrounds (personal and/or childbirth related) influenced their decision making. *Diverging paths of decision making* provides more detailed insights into how and why women's different backgrounds and experiences of childbirth and maternity care influenced their decision to freebirth. *Converging path of decision making*, outlines the commonalities in women's narratives in terms of how they sought to validate their decision to freebirth.

Conclusion: The UK based midwifery philosophy of woman-centred care that tailors care to individual needs is not always carried out, leaving women to feel disillusioned, unsafe and opting out of any form of professionalised care for their births. Maternity services need to provide support for women who have experienced a previous traumatic birth. Midwives also need to help restore relationships with women, and co-create birth plans that enable women to be

active agents in their birthing decisions even if they challenge normative practices. The fact that women choose to freebirth in order to create a calm, quiet birthing space that is free from clinical interruptions and that enhances the physiology of labour, should be a key consideration.

SEMINAR 5
Seeding baby's Microbiome – what CAN we tell parents?

Speaker: Bridget Supple, Parent Educator, Birmingham Women's Hospital; NCT; TAMBA

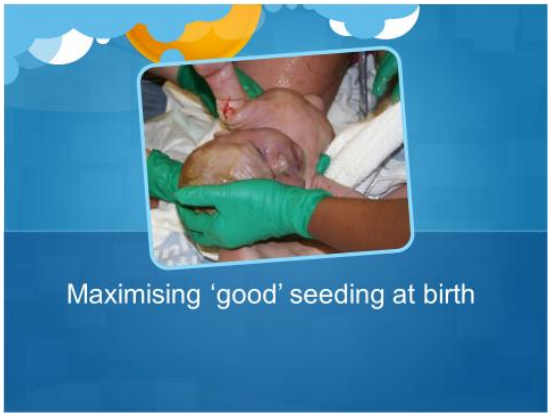
The last few years has seen an explosion in the knowledge about the microbiome, gut bacteria and its effect. Rarely a week goes by without a new piece of research showing a possible correlation between gut bacteria and health, anxiety, ADHD, Autism or obesity. Increasingly the evidence shows that the bacteria that gets there first, that 'colonises' the gut has the best chance of being the dominant one, so how do we make sure baby gets the right 'seeding' of the microbiome at birth?

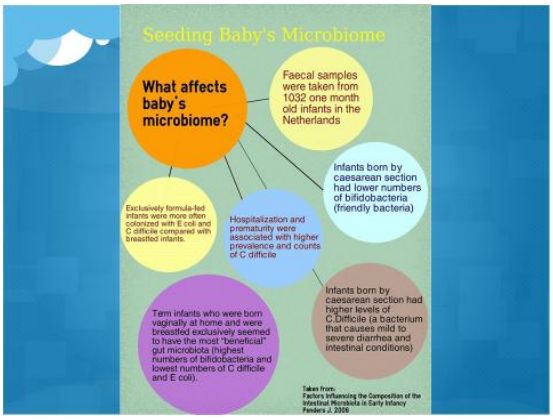
What DO we know and what can we tell parents?

Bridget Supple has been teaching parents about birth, brain development and more recently the microbiome, for over a decade and runs the Facebook page "Seeding Baby's Microbiome" a source for health professionals and parents alike to keep up to date with the latest science and understanding of giving baby the best microbial start.

While attachment and responsiveness is a primary source of understanding long term outcomes the recent discoveries about the Microbiome have changed how we view the importance of the birth mode and early experience as having massive effects on baby's future.

In this talk we will review the current understanding of seeding baby's microbiome and look at what we can tell parents in light of current knowledge.





SEMINAR 6
MiApp: a national, standardised electronic record to enhance partnership between mother and clinician and improve quality of maternity care

Speaker: Angela Mushing, Specialist Midwife, Perinatal Institute
Authors: Rachel White, Sally Giddings and Jason Gardosi

Good record keeping is essential for clinicians to give safe care to women during pregnancy and birth, and for women to be fully informed for decision-making. Current practice usually involves clinicians manually completing woman-held maternity notes as the primary source of information, and duplicating this information to keep providers informed.

Such double entry of information is expensive and time-consuming and has resulted in poor data quality and communication within maternity care.

Method:

MiApp is being developed by a team of midwives from the Perinatal Institute and a software team from Patient Knows Best (PKB), in consultation several NHS Trusts. The application is designed as a personalised, electronic version of the standardised hand-held paper record still used in the majority of pregnancies in England. The system uses a standardised dataset which is consistent with the maternity payment pathway, the national Maternity Service Secondary Uses Dataset, and key performance indicators and outcome measures.

Results:

- MiApp puts the mother in control of her own health record, which she can access on her mobile phone, tablet or home computer
- Information can be shared instantly with primary, secondary and social care providers, including risk alerts, clinical referrals and management plans
- The app is designed to contain rich information inc. videos link to useful websites and translations into 18 languages
- Content can be updated on a regular basis in line with best practice and national guidelines.

Conclusion:

MiApp puts the mother at the centre of care and in control of information collected about her and her pregnancy. It is able to fulfil the recent national calls that the NHS provide patient access to healthcare records, deliver patient centred models of care, standardise reporting and improve multi professional working [1, 2]. Pilots are due to start in autumn, with launch planned by the end of 2016.

References:

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LUNCHTIME SEMINAR 1
Healthy backs for midwives

Speaker: 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 midwifery carer. The presentation consists of specific exercises, movements and postures designed for Midwifes, to relieve and prevent musculoskeletal disorders including back pain.

LUNCHTIME SEMINAR 2
Reiki and the birth experience

Speaker: Wendy Henry, Sandwell and West Birmingham Hospital NHS Trust

Reiki is as ancient natural healing therapy, which helps the body to return back to its natural state if there are any imbalances. This type of holistic alternative therapy has become increasingly popular over the years. It is not known to replace conventional medicine if acute or chronic illness is already present, but complements the treatment.

Reiki therapy is known as a non-invasive hand's on treatment which uses the universal natural life energy to adjust the body to normal rhythm. The energy flows through the body to release tension, pain and blockages, increasing health and wellbeing; mentally, physically and spiritually.

Reiki is good throughout pregnancy, it can help reduce nausea, anxiety, relieve the pain in joints and labour. Reiki helps relax the body, to increase inner peace and can help speed up postnatal recovery.
Reiki therapy was dismissed for many years by the Medical community because there was no clear validity of its effectiveness. However, things are now changing and Reiki is gaining a new respect by Medical professionals. There

have been some controlled and evidenced based studies in specific medical fields which have shown positive outcomes for people with illness and chronic pain.

Though the best way to understand and know Reiki is to experience it yourself. Every living creature can benefit for having a Reiki treatment from adults, infants, animals and plants.

Jeri Mills, M.D, *Reiki and the birth Experience*; http://www.thehealingpages.com/reiki-and-pain
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SEMINAR 7
Achieving the Government's ambition to reduce smoking in pregnancy

Speaker: Jenn Ruddick, Senior Policy & Campaigns Office,Action on Smoking & Health

Authors: Linda Bauld, Institute for Social Marketing, School of Health Sciences, University of Stirling, Francine Bates, Chief Executive, The Lullaby Trust, Hazel Cheeseman, Director of Policy, ASH

Abstract:

Over the last few years smoking rates among pregnant women have started to fall more quickly. This has been achieved through Government, voluntary sector and academia working together. The Smoking in Pregnancy Challenge Group is a collaboration of charities, academia and Royal Colleges who pooled their expertise to publish a report in 2013. Following the successful implementation of many recommendations and renewed progress in this area the in late 2015 Group published a review of the original recommendations, defining new goals for further progress in this area the next five years.

Over this period the Government have launched the Stillbirth Care Bundle and the Maternity Safety Campaign key to the delivery of which is reducing rates of smoking in pregnancy.

However, without continued action and the full implementation of NICE Guidance the progress to date could be lost and there is still much left to be achieved. In the region of 70,000 infants every year are born to mothers who smoke and smoking is the single biggest modifiable risk factor for poor birth outcomes as well as a major cause of inequality in child and maternal health.

Our workshop will cover:

- Current situation in England
- Priority areas for action and how we make further progress reducing smoking in pregnancy
- The resources available to support practice

This session will include an opportunity to:

- Share what is happening locally
- How the Smoking in Pregnancy Challenge Group can support future practice

SEMINAR 8
Student led antenatal classes

Speaker: Clare Winter, Senior Lecturer, University of Brighton

This paper explores the development of student midwife led antenatal classes, where students will develop skills in planning and delivering a series of classes for women and their partners.

Local hospitals no longer provide Antenatal classes or parent education so student midwives have little opportunity to experience and partake in this area of the role of the midwife. Anecdotally, students and midwives report that women are keen to attend classes and would value them. It has also been shown that pregnancy is an important time of transition, particularly for first time parents. There is evidence that antenatal classes help support that transition particularly forming networking and support groups for those who attend the classes (Deave, Johnson and Ingram 2008)

The project focuses on experimental learning whereby students apply their knowledge to real-world problems (Wurdinger and Carlson 2010). It bridges the theory – practice gap by providing an authentic learning environment where learners see the relevance of what they are doing which results in increased motivation (Ambrose et al 2010).

Students plan, advertise, deliver and audit a set of antenatal classes under the supervision of midwifery lecturers. The pilot will be used to develop a substantive module which will give students experience of team working, organisation and leadership as well as providing a meaningful and responsive community service.

There is space for the development of care provision alongside, and outside, the National Health Service (National Maternity Review 2016). This project gives students the space and tools to think creatively about ways of delivering locally responsive care. The pilot takes place in a healthcare setting already owned by the university. This gives the opportunity for the development of meaningful inter-professional engagement in developing future programmes for women.

This paper will reflect on the development and pedagogical underpinning of the project, and will share findings and experiences from the first completed pilot.

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SEMINAR 9
Promoting newborn care in Zambia: exploring challenges and opportunities

Speaker: Faith Kayembe, Senior Lecturer Midwifery, Canterbury Christ Church University

Aim: To share the findings of a collaborative initiative between an educator and a health partnership to address the needs of the newborn in Zambia.

Objectives: Whilst overall global child mortality rates have reduced considerably, concern remains in regards to the comparatively slow pace in the decline of neonatal deaths (Central Statistical Office (CSO) 2015; World Health Organisation (WHO) 2014; Bhutta et al 2014).The author discusses a collaborative initiative involving Canterbury Christ Church University and the Brighton-Lusaka health partnership to promote newborn care through a range of activities: a scoping exercise on neonatal care, facilitation of neonatal resuscitation training and participation in stakeholder discussions in the UK and abroad. Both currency and urgency of the subject of neonatal health with reference to relevant host country and global priorities are underlined (Chisunka 2013, WHO 2014).

The scoping exercise involves a qualitative approach primarily using observational methods on a maternity ward and neonatal unit in Zambia. Staff discussions, documents and meeting outcomes were also included. Findings were analysed, key themes identified and suggestions for improvement made. Relevant implications for the patient experience, in this case the newborn and the maternal-infant unit, are at the heart of this work. The challenges and opportunities inherent in undertaking this activity are explored. Amongst other issues the author emphasises challenges of communication between diverse cultures and managing expectations. Opportunities include knowledge exchange, learning about other cultures and ways of thinking, cultivating the values of partnership, respect as well as incorporating experience and research into teaching.

A future prospect to address some of the findings from the above activity through the development of a responsive programme of newborn resuscitation is planned for August 2016. Therefore despite the challenges, clear opportunities exist for meeting the needs of women and their families by engaging in strategies to save lives.

References

Bhutta ZA, Das JK, Bahl R, Lawn JE, Salam RA, Paul VK, Sankar MJ, Blencowe H, Rizvi A, Chou V, Walker N (2014) Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? *The Lancet* Vol.384:9940 p.347-370

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SEMINAR 10
Early life nutrition: the importance of nutrition before, during and after pregnancy

Speaker: Jacqueline Lowdon, Paediatric Dietician and Team Leader in Therapy& Dietetics, Manchester Children's Hospital

This presentation will address:

- The importance of Early Life Nutrition as a major influencer of health in later life
- First 1,000days and the window of opportunity from conception to toddlerhood
- Professor David Barker and foetal origins hypothesis
- Rise of non-communicable diseases and how we can reduce health risks in later life through early intervention
- Importance of nutrition pre-conception
- Importance of nutrition during pregnancy
- Importance of nutrition while breastfeeding

SEMINAR 11
Impact of the antenatal mental health liaison clinics in Birmingham on admissions to the mother and baby unit

Speaker: Emily Barry, Medical Student, University of Birmingham

Authors: Dr Hassan Kapadia, Consultant Perinatal Psychiatrist, Dr Deirdre Lane, Senior Lecturer; University of Birmingham

Objectives/Background
Antenatal Mental Health (AMH) Liaison clinics in maternity units were introduced in Birmingham in 2010 to try to improve perinatal care by identifying and treating women with mental health problems in the perinatal period. This study evaluated the impact of the AMH liaison clinics on admissions to the Birmingham Mother and Baby Unit (MBU) and the demographic and clinical characteristics of those admitted.

Methods
Demographic and clinical characteristics were collected for all MBU admissions from inception of liaison clinics (1997) to 2014, through interrogation of medical records.

Results
882 (97.8%) records were evaluated. From 1997-2014, most women admitted to the MBU were White (65%), 19.8% were Asian and 11.5% Afro-Caribbean. Median (IQR) age of women admitted to MBU increased (28 (9) vs. 31 (6) years) following introduction of the liaison clinics, with an increase in the frequency of women admitted with more severe psychiatric diagnoses. Length of stay in the MBU increased following introduction of liaison clinics 40 (56) vs. 46 (52) days.

Conclusions
No reduction in admissions to the Birmingham MBU was evident following the introduction of liaison clinics, but fewer women were admitted with moderate psychiatric disorders. Although there has been an increase in admissions to the MBU from ethnic-minority groups over time, more needs to be done to encourage these women to engage with mental health services.

Keywords
Antenatal liaison clinic; maternal mental health; perinatal

References
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SEMINAR 12
CALMED (Collaborative Action to Lower Maternity Encountered Deaths). Conclusion of a 3-year project in India, March 2013-February 2016

Speakers: Manjit Roseghini, Head of Midwifery and Women's Health and **Caroline Duncombe**, Midwife, Whittington Hospital

In 2012 Rotary International recruited a team to "Train the trainers" for their CALMED project (Collaborative Action in Lowering Maternity Encountered Deaths) in Jawhar, about 150 miles north of Mumbai. The aim was to develop a structured training programme in basic obstetric skills to ultimately be rolled out to health workers on the front line in Jawhar over a 3 year period, involving 3 visits.

The team was recruited by interview and comprised of 2 midwives, 1 paediatrician, 1 obstetrician and 1 team leader from Rotary. Manjit Roseghini and Caroline Duncombe were the midwives on the team. They were both experienced midwives, were ALSO instructors and Supervisors of Midwives.

The MMR in the Jawhar area was high with local risks including malnutrition and adolescent pregnancies through to delays in recognition of urgent, serious medical problems; in accessing transport and in receiving expert, skilled emergency care, even when in a hospital, clinic or at home. 47% of women had an institutional delivery and 53% had their births assisted by a skilled birth attendant in the community. As many as 49%of pregnant women did not have as many as three antenatal visits during pregnancy (UNICEF, 2013).

In March 2013 the team went to Mumbai and met 13 obstetricians/gynaecologists to train as trainers who had a varying amount of experience, from nearly qualified to retired. A variety of training methods were developed including training manuals and manikins to reinforce training methods. Manikins were left with the trainers to enable effective training for basic medical staff and nurses, in order to cascade and spread their acquired skills and knowledge.

The team did some new and refresher training in January 2015 and the final, wrap up visit is planned for February 2016. We would like to present an overview of our experiences over the 3 years.

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