THE ROYAL COLLEGE OF MIDWIVES

INMO
Irish Nurses and Midwives Organisation
Working Together

RCM NI / INMO

All Ireland Midwifery Conference

Thursday, 12 October 2017

Armagh City Hotel, Armagh, Northern Ireland

Theme: 'Actions Speak Louder than Strategies'

CONFERENCE PROCEEDINGS

Category I Approval from NMBI = 5 CEUs

All Ireland Annual Midwifery Conference

'Actions Speak Louder than Strategies'

Royal College of Midwives NI / Irish Nurses and Midwives Organisation

12th October 2017 - Armagh

Charlotte McArdle

Chief Nursing Officer

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Maternity Strategies for Ireland

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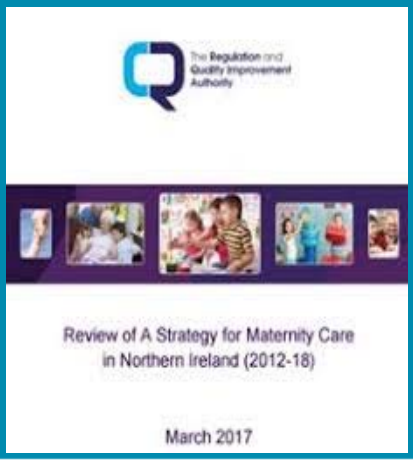
Action = Implementation



How are we doing?

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Bengoa Report 2016

'The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it'

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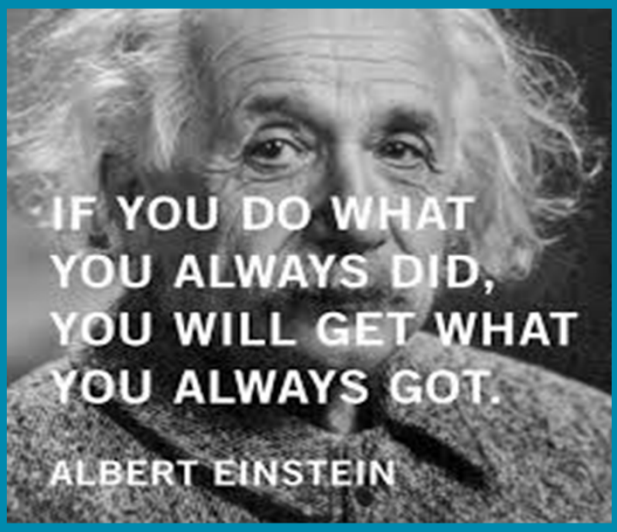

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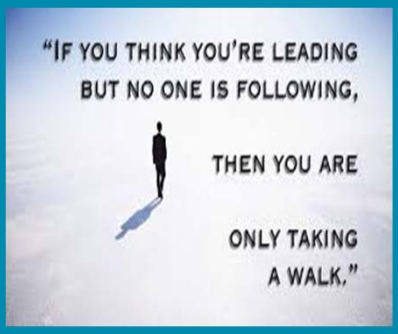
Change

- Doing things differently

- Leadership



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Health and Wellbeing 2026: Delivering Together

The Vision for a new model of Health and Social Care in Northern Ireland is:

- Patient centred
- Population health model
- Delivered at sustainable cost

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The approach

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.

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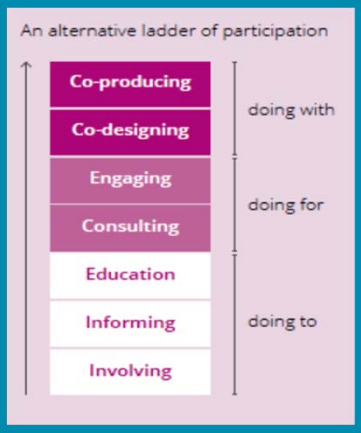
Co-Production



- The design of new and reconfigured services will be taken forward on the basis of co-production and co-design

DH 2016, Health and Wellbeing 2026; Delivering Together pg 20

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Nursing and Midwifery Task group

- From Delivering Together, a Nursing and Midwifery Task Group was appointed.
- This group will report to the Health Minister by Spring 2018.
- Reporting on how the contribution from nursing and midwifery can be maximised to improve outcomes for the population.

Improvement Workshops:

- Workforce
- Population health
- Delivery of Nursing and Midwifery Care (Acute and Community)

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HSC Collective Leadership Strategy

- Values both formal and informal leadership
- Takes risks and learns from mistakes
- Supports continuous improvement

[Draft September 2017]

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- Recognises that leadership comes from all levels
- Enables effective and meaningful personal and public involvement leading to co-production and a commitment to **'no decision about me without me'**

> Collective leadership creates the foundation of a strong, supportive organisational culture.

> Our leaders at all levels need to develop strong networks, supportive alliances and trusting relationships within and across organisational, professional and geographical boundaries.

> Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

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Key Leadership Behaviours

1. Person-centeredness	Be consistently person-centered in word and deed
2. Front Line Engagement	Be a regular authentic presence at the front line and a visible champion of improvement
3. Relentless Focus	Remain focused on the vision and strategy
4. Transparency	Require transparency about results, progress, aims, and defects
5. Boundarilessness	Encourage and practice systems thinking and collaboration across boundaries

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Why is midwifery leadership important?

https://youtu.be/0NmWOHuy-o8

https://www.youtube.com/watch?v=0NmWOHuy-o8&feature=youtu.be

Key Findings

- The Health and Social Care Northern Ireland Workforce, at 31st March 2017, stood at 64,317 (55,876.9 whole-time equivalent [WTE]).
- The largest single staff group was Qualified Nurses & Midwives, at 15,134 WTE.

From: Health and Social Care Northern Ireland Quarterly Workforce Bulletin March 2017

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Florence Nightingale

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Values and beliefs

Prerequisites

- Professionally competent
- Developed interpersonal skills
- Commitment to the job
- Clarity of beliefs and values
- Knowing 'self'

Person centred processes

- Working with the patient's beliefs & values
- Engaging authentically
- Sharing decision making
- Being sympathetically present
- Providing holistic care

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Person centredness

- Globally adopted; translated into 3 languages
- Embedded in practice
- Underpins delivery of improvements in practice
- Influences and underpins strategy and policy frameworks
- Used as a theoretical framework in research and as a curriculum framework
- Identifies outcomes and has driven instrument development
- Contributed to theory development and further testing

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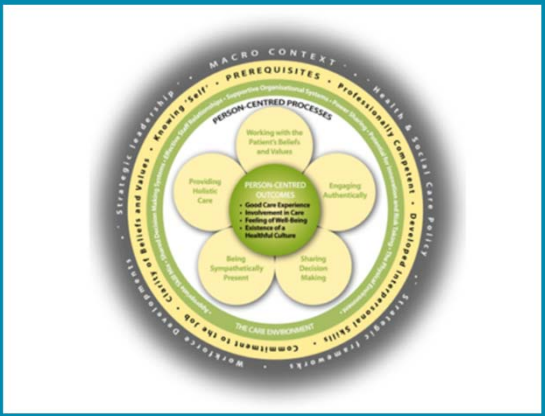
Person Centred Practice Framework

(McCormack & McCance 2017)



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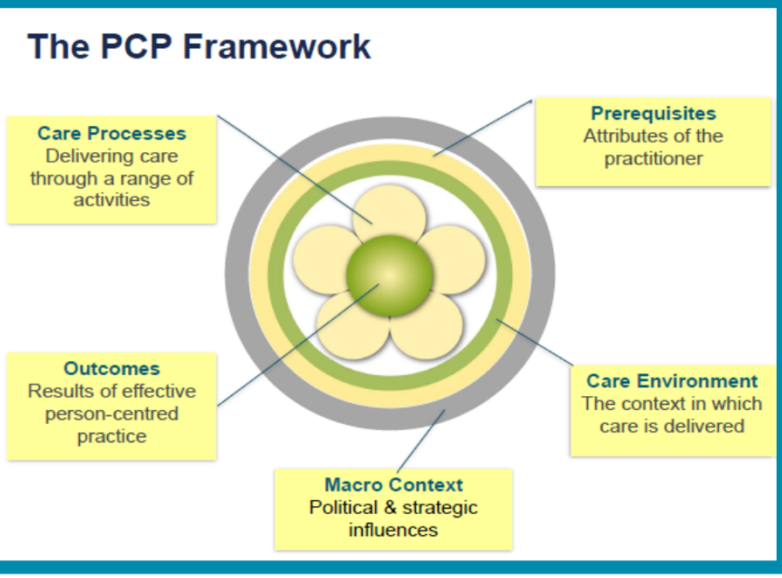
The PCP Framework



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Person centred outcomes

- Good care experience
- Involvement in care
- Feeling of wellbeing
- Existence of a Healthful culture

Midwives, mum & baby, birthing pool and past President of the RCM, Lesley Page in Daisy Hill

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Enabling professionalism

- The professionalism of nurses and midwives has always been essential to good care
- Enabling professionalism was led by the Chief Nursing Officers of the four countries, and brought together nursing and midwifery leaders from across the UK.

https://www.nmc.org.uk/standards/professionalism/read-report/

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Global Professions

European strategic directions for strengthening nursing and midwifery towards Health 2020 goals (WHO 2015)

- This is the first such document produced in the European Region, developed as a result of extensive collaboration with senior nurse and midwife leaders and consultation with policy makers.
- The document aims to enhance the contribution of nurses and midwives improving the health and well-being of populations, reducing health inequalities, strengthening public health and ensuring sustainable, **people-centred health systems**.

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Global Strategic directions

- The WHO Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020 is the principal global guiding document for the development of nursing and midwifery in Member States.
- The launch of this document took place at the Global Forum for Government Chief Nursing and Midwifery Officers on 18 May 2016, Geneva, Switzerland

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WHO Director-General Elect
Dr. Tedros Adhanom Ghebreyesus

- "I want to start by thanking you all for your services and your invaluable contributions and sacrifices at the frontlines of healthcare systems around the world and your leadership at all levels from transforming policies to saving lives.
- Your service and leadership are essential to increasing access to quality and affordable healthcare around the world"

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Midwives (Ireland) Act 1918

100 year Anniversary in 2018 – what is your story?

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Then (1918 onwards)

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And now… Our future

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Your leadership

- You have the opportunity to make a difference in whatever role you take
- You affect families' lives
- Your leadership skills are important especially in advocating for what is best for the women and babies you care for
- Always seek excellence in your care and outcomes

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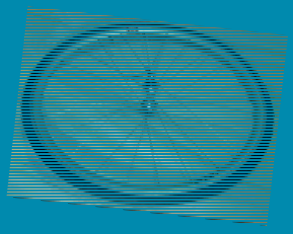
Midwives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Midwives

- Emotionally intelligent
- Know how to get things done
- Have a strong value base
- Have a strong sense of equality
- Are a force for good and a powerhouse for change
- Influence and improve:
  - Practice
  - Education
  - Policy

And most importantly…
- people's lives

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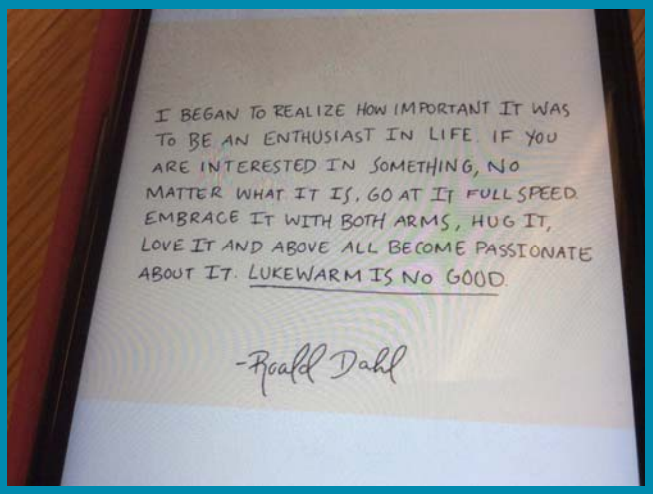

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Enjoy the rest of today's conference

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All Ireland Annual Midwifery Conference
Armagh City Hotel

Una Turbitt
una.turbitt@hscni.net
A.D. Public Health Nursing
12 October 2017

HSC Public Health Agency

Improving Your Health and Wellbeing

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Improving Your Health and Wellbeing

Related NI Strategies

- Making Life Better
- Programme for Government (draft)
- Quality 2020
- Early Intervention Transformation Programme
- Stopping Domestic and Sexual Violence and Abuse in Northern Ireland' Strategy
- Public Health: Breastfeeding, Sexual Health, Tobacco, Obesity, Alcohol, Mental Health …..

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Improving Your Health and Wellbeing

Strategic Themes

- Give every child the best start in life
- Support women to be healthier at the start of pregnancy
- Provide safe, effective, accessible midwifery led care and high quality specialist care when needed
- Promote positive experiences for mothers, babies & families
- Provide good information advice and support for families after the baby's birth
- Tackle deprivation & inequalities
- Involve service users in service design and transformation

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Outcomes Based Accountability

Key Questions:

1.How Much?
2. How well?
3. Is anyone better off?

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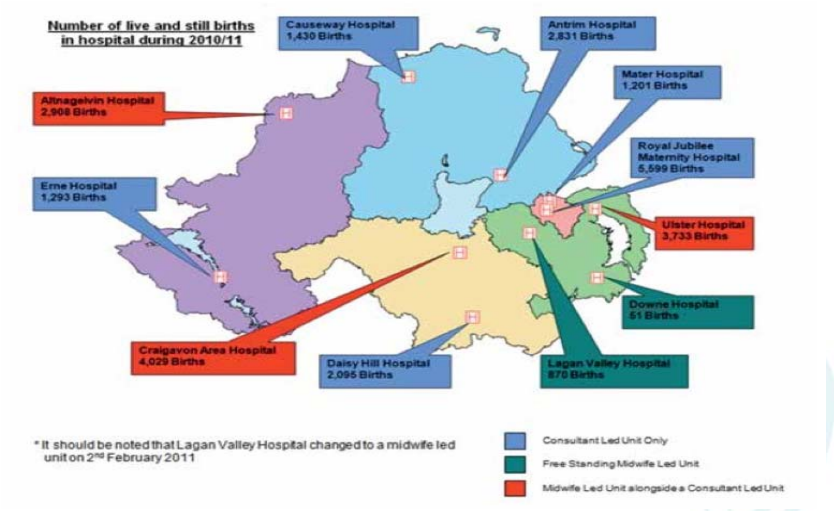
Improving Your Health and Wellbeing



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Improving Your Health and Wellbeing

Implementation through Leadership & Design

- Clear vision
- Clear goals, actions & updates
- Flexible & responsive to emerging strategy & the need for change
- Data analysis - inform, test & evaluate progress

Implementation structure and processes

Multidisciplinary steering and working groups

Co-chaired
e.g. midwife and obstetrician

NI Maternity Quality Improvement Collaborative

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Improving Your Health and Wellbeing

Strong Collaboration

Owned & Shared by:

Women
Midwives
Maternity Support Staff
Medical Staff
General Practitioners
Health Improvement Teams
Universities, CEC, NIPEC
DoH, PHA, HSCB, HSCTs, BSO

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Implementation Groups

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Complimentary regional work-strands

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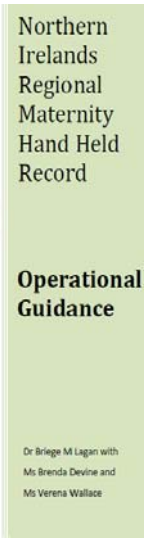
Evidence of Success

Promote a culture of normalisation of pregnancy and birth in population planning, commissioning and the provision of maternity care

- ✓***Midwife Led Care – 2 free standing birthing units and 5 'along side' birthing units***
- ✓***GAIN Guideline for Admission to Midwife-Led Units***
- ✓***E-referral by GPs & midwives to maternity services***
- ✓***Regional Maternity Records (woman held)***
- ✓***Core Pathway for Pregnancy Care (2015)***



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Work will progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice

- ✓ ***Regional Dashboard has been agreed***
- ✓ ***Practice Tools to assist regional learning:***
  - ***CTG stickers for antenatal and Intra-partum***
  - ***Obstetric Early Warning Score Chart***
  - ***Matrix for prevention of early onset neonatal Group B streptococcal diseases***
  - ***Regional inter-uterine transfer proforma***

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The NIMAT system will be continually reviewed and updated to ensure it is 'fit for purpose' to promote coordinated regional data collection, in line with data protection principles and information governance.

- ✓ ***Revised Regional Steering Group Structure***
- ✓ ***All Trust implementation***
- ✓ ***Updated to new web based system – better data production***
- ✓ ***Robson groups available on NIMATs to assist with monitoring intervention levels***
- ✓ ***Female Genital Mutilation***

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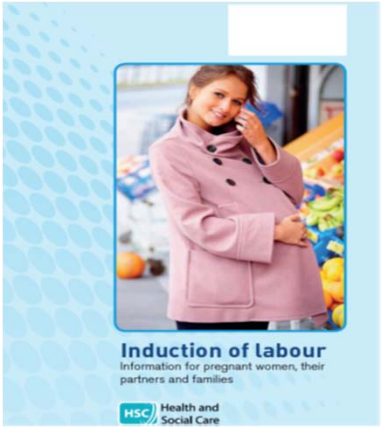
Support for women, babies & families
Support for professional practice



Regional In Utero Transfer Proforma

Woman's Details/sticker			**Date and Time of Transfer:**	
Name:			**Name and Contact Details of Referring Unit:**	
DOB:			**Name and Contact Details of Referring Doctor:**	
H+C number:			**Name and Contact Details of Receiving Unit:**	
Address:			**Name and Contact Details of Receiving Doctor:**	
Current Pregnancy:	Parity:		EDC:	Gestation:
No. of fetuses:	1		2	Other:
No. and mode of previous births:	Vaginal Births:		C/S births:	
Contraindication to vaginal delivery:	No		Yes (please state):	
Reason for transfer:				
If woman is actively bleeding then check with senior medical staff whether it is safe to proceed with transfer				
Maternal Condition:	Temperature	Pulse	Blood pressure	Resp Rate
Contractions	Yes	No	Frequency/strength:	
Membranes:	Intact	Ruptured	If ruptured, date, time and colour of liquor:	
Fibronectin	Positive		Negative	Not indicated
Speculum/Vaginal Examination Findings (indicate date and time):				Speculum/VE not indicated
Details of tocolysis:				Tocolysis not required
Details of any Rx given for BP:				No antihypertensives required

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Maternity care in the right place, with the right people looking after you and your baby will help ensure the best outcomes.

- Birth in a relaxed environment with low intervention rates for women with a straightforward pregnancy
- Medical care from specialist teams if you need it, to ensure a safe birth for you and your baby
- Talk to your midwife and/or doctor about what you would like so that the care offered meets your individual needs and choices

What if a problem arises?

You will be continually assessed as your pregnancy, labour and postnatal period progresses.

- Contact your midwife or local maternity unit immediately if you have any concerns about your pregnancy
- Contact your own GP about any other medical problems just as you would normally do
- If your midwife or GP has any concerns they will discuss this with you and arrange for an obstetrician to see you
- Emergency 24 hour medical cover is available by obstetricians, paediatricians and anaesthetists should this be necessary

Maternity Service Liaison Committees (MSLC)

Ask the midwife or visit your Trust's website to learn more about local MSLC groups and how you can join – just remember your views really matter and you can help us to improve services. Be sure to let the MSLC know when problems/concerns are resolved.

Further Information

Maternity Services' details and links to care pathways, leaflets, The Pregnancy Book, websites, local antenatal education sessions and other useful information is available on our Trust websites.

www.belfasttrust.hscni.net www.northerntrust.hscni.net
www.southerntrust.hscni.net www.setrust.hscni.net
www.westerntrust.hscni.net

If you require general information, about the services, please visit the regional websites.

www.publichealth.hscni.net www.dhsspsni.gov.uk
www.nidirect.gov.uk

Supervisor of Midwives

If you wish to discuss any particular aspects of your maternity care, you can contact a local Supervisor of Midwives (SOM) who will be happy to help.

The 24 hour 'SOM On-Call' telephone number for your area is available in your Maternity Notes or visit www.nipec.hscni.net/supervisionofmidwives

Feedback

Your feedback is very important as it helps us to monitor and improve our services so please use the feedback link on the Trust website or ask staff for a feedback card.

Now you are pregnant

Choices for Maternity Care in Northern Ireland

HSC Health and Social Care

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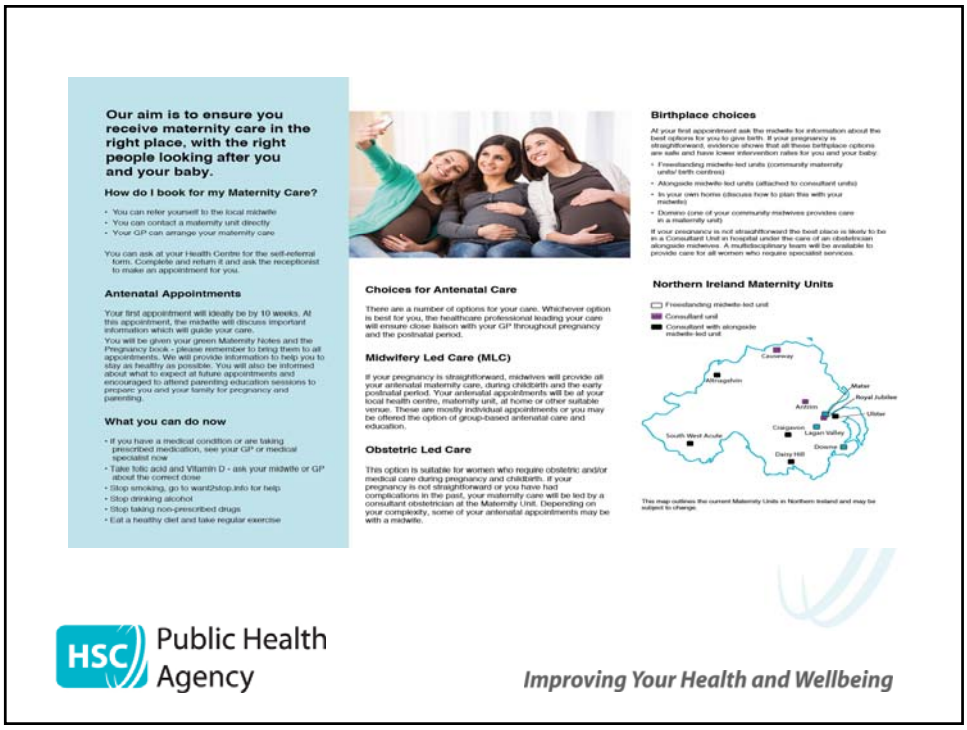

Our aim is to ensure you receive maternity care in the right place, with the right people looking after you and your baby.

How do I book for my Maternity Care?

- You can refer yourself to the local midwife
- You can contact a maternity unit directly
- Your GP can arrange your maternity care

You can ask at your Health Centre for the self-referral form. Complete and return it and ask the receptionist to make an appointment for you.

Antenatal Appointments

Your first appointment will ideally be by 10 weeks. At this appointment, the midwife will discuss important information which will guide your care.

You will be given your green Maternity Notes and the Pregnancy book – please remember to bring them to all appointments. We will provide information to help you to stay as healthy as possible. You will also be informed about what to expect at future appointments and encouraged to attend parenting education sessions to prepare you and your family for pregnancy and parenting.

What you can do now

- If you have a medical condition or are taking prescribed medication, see your GP or medical specialist now
- Take folic acid and Vitamin D - ask your midwife or GP about the correct dose
- Stop smoking, go to want2stop.info for help
- Stop drinking alcohol
- Stop taking non-prescribed drugs
- Eat a healthy diet and take regular exercise

Choices for Antenatal Care

There are a number of options for your care. Whichever option is best for you, the healthcare professional leading your care will ensure close liaison with your GP throughout pregnancy and the postnatal period.

Midwifery Led Care (MLC)

If your pregnancy is straightforward, midwives will provide all your antenatal maternity care, during childbirth and the early postnatal period. Your antenatal appointments will be at your local health centre, maternity unit, at home or other suitable venue. These are mostly individual appointments or you may be offered the option of group-based antenatal care and education.

Obstetric Led Care

This option is suitable for women who require obstetric and/or medical care during pregnancy and childbirth. If your pregnancy is not straightforward or you have had complications in the past, your maternity care will be led by a consultant obstetrician at the Maternity Unit. Depending on your complexity, some of your antenatal appointments may be with a midwife.

Birthplace choices

At your first appointment ask the midwife for information about the best options for you to give birth. If your pregnancy is straightforward, evidence shows that all these birthplace options are safe and have lower intervention rates for you and your baby:

- Freestanding midwife-led units (community maternity units/ birth centres)
- Alongside midwife-led units (attached to consultant units)
- In your own home (discuss how to plan this with your midwife)
- Domino (one of your community midwives provides care in a maternity unit)

If your pregnancy is not straightforward the best place is likely to be in a Consultant Unit in hospital under the care of an obstetrician alongside midwives. A multidisciplinary team will be available to provide care for all women who require specialist services.

Northern Ireland Maternity Units

Freestanding midwife-led unit
Consultant unit
Consultant with alongside midwife-led unit

This map outlines the current Maternity Units in Northern Ireland and may be subject to change.

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Feeling your baby move is a sign they are well.

KICK FLUTTER SWISH/ROLL

MOVEMENT

Most women usually begin to feel their baby move between 18 and 24 weeks of pregnancy.

A baby's movements can be described as anything from a kick, flutter, swish or roll. The type of movement may change as your pregnancy progresses. If by 24 weeks you have never felt your baby move, you should contact your midwife, who will check your baby's heartbeat and, if needed, arrange an ultrasound scan.

How often should my baby move?

There is no set number of normal movements. Your baby will have *their own pattern of movements* that you should get to know. The pattern may be different at different stages, especially towards the end of pregnancy.

It is *not true* that babies move less towards the end of pregnancy.

Why are my baby's movements important?

A reduction in baby's movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a stillbirth noticed their baby's movement had slowed down or stopped.

Do not use any hand-held monitors, dopplers or phone apps to check your baby's heartbeat. Even if you detected a heartbeat, this does not mean your baby is well.

Do not wait until the next day to seek advice if you are worried about your baby's movements.

What if my baby's movements are reduced again?

If, after your check up, you are still not happy with your baby's movements, you must contact either your midwife or maternity unit straight away, even if everything was normal last time. If you think your baby's movements have slowed down or stopped, contact your midwife or maternity unit immediately (it is staffed 24hrs, 7 days a week). Do not worry about phoning, no matter how many times this happens.

NEVER HESITATE TO CONTACT

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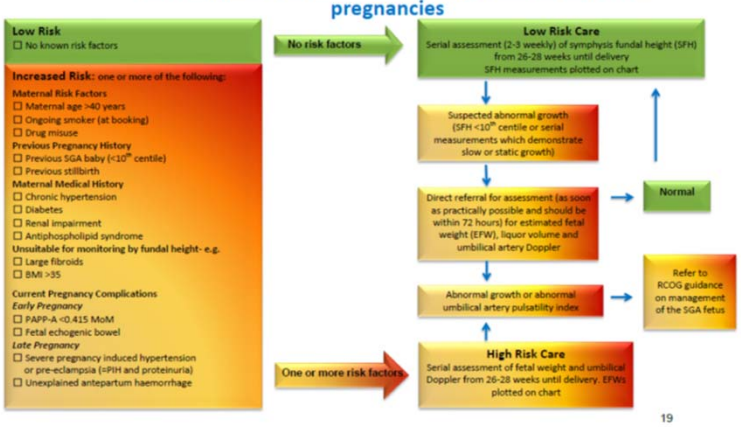
Algorithm and Risk Assessment Tool: Screening and Surveillance of fetal growth in singleton pregnancies



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Improving Your Health and Wellbeing


Learning Matters

QUALITY 2020

June 2015

Special maternity edition

Introduction

Welcome to a special 'maternity' edition of the Learning Matters Newsletter.

Investigation reports into maternity serious adverse incidents (SAIs) frequently identify regional learning. This is usually disseminated through:

- Safety & Quality learning letters and reminder of best practice letters (available to HSC staff at http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html)
- Occasional articles in the Learning Matters Newsletter (also available at the above website)
- The Maternity Quality Improvement Collaborative.

This special edition of the Learning Matters Newsletter presents six articles on topics which have been recognised to be recurring themes in a number of maternity SAIs.

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Care of women who have had a previous caesarean section..... X

Antenatal Fetal Growth Monitoring..... X

Obstetric Early Warning Scores..... X

Operative vaginal delivery..... X

Human Factors and Situational Awareness..... X

Inadequate arrangements for elective caesarean section..... X


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Inadequate arrangements for elective caesarean section..... X

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Early Intervention Transformation Programme

Group-based ante-natal education and care (GRfB)

100% value the same midwife

100% prepared me to nurture my baby

99% GRfB is a good idea

98% enjoyed shared experience

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Improving Your Health and Wellbeing

RQIA Review of Maternity Strategy Implementation (March 2017

Review of A Strategy for Maternity Care in Northern Ireland (2012-18)

March 2017

- Significant achievements recognised
- Strong commitment from leaders and teams
- Achievements in regional public health strategies and local initiatives
- Antenatal Care Pathway
- Safer intrapartum care
- Improved information for women and access to midwife-led care

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Ongoing Work & Challenges

Workforce
Pre-conceptual care
Breast feeding rates
Smoking in pregnancy; obesity; co-morbidities
Drugs, alcohol, domestic abuse
Flu immunisation
Recurrent miscarriages/ ectopic pregnancy
Post-natal pathway
Peri-natal mental health care
Sustaining group based care and education for first time parents/families
Reducing infant mortality and still births
Making Every Contact Count

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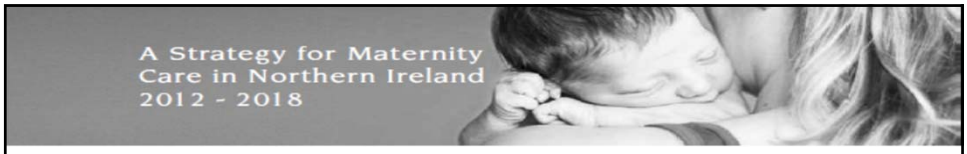
Improving Your Health and Wellbeing



- Further progress is dependent on continued strong:
- Leadership
- Vision
- Implementation plan and structure
- Focus on regional improvement
- Collaboration – with emphasis on GPs & pharmacists
- Data
- Commitment
- Willingness to implement new approaches & change
- Sharing ideas, experience and learning throughout the island of Ireland

HSC Public Health Agency

Improving Your Health and Wellbeing

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Women and Infants' Health Programme

Kilian McGrane
National Programme Director
12th October 2017

Maternity Strategy

Creating a Better Future Together

Context for the development of the Strategy

- Portlaoise (recommendations)
- "Savita"
- Portiuncula
- Flory Report
- Smaller Hospitals Framework
- Loss of confidence in aspects of the service
- Negative media coverage, and political concerns

Strategy Development

- The recommendation for the development of a Maternity stemmed from a number of the reports into adverse event
- CMO in DoH and HIQA saw the need for a definitive strategy framework to direct our maternity services
- Large working group established (30+ people) developed a excellent document within 12 months

Creating a Better Future Together

- Strategy launched in January 2016
- Comprehensive strategy document to reflect challenges and opportunities in Irish Maternity System
- Extensive consultation around Strategy development
- Well received document, with good political and community support

Next Implementation

- Before the launch of NMS it was decided that a programmatic approach would best way for implementation
- The decision was to establish a Programme Office (NWIHP) comprised of:
  - National Programme Director
  - Director of Midwifery
  - Clinical Director
- Unfortunately the recruitment took over 12 months

NWIHP 2017

- National Programme Director January 2017
- Dr Peter McKenna appointed as CD March 2017
- Angela Dunne appointed as DOM in March, transitioning from current role
- QPS appointment in train
- Slow start but no more excuses

Role of NWIHP

- NWIHP covers obstetrics, neonatology and gynaecology
- Implementation of NMS top priority
- Benign gynaecology a very serious issue, and will be addressed in parallel

Strategic priorities

NMS Objectives

- NMS underpinned by 4 principles
  - Health and Wellbeing
  - Safe, high quality, consistent, women centred care
  - Choice
  - Resources, governance and leadership
- Everything we do needs to be tested against those principles
- Designing the system around the needs of women and infants

Programmatic Approach to Delivery

- Programmatic approach is not new for the HSE
- NCCP set the template back in 2007
- A programmatic approach can work where there is a clear strategy, dedicated team and the necessary support.

NCCP Approach

- Building NWIHP model on success of NCCP
- Well developed strategy
- Excellent clinical leadership
- Clinical support across the system
- DoH/HSE support
- Cross party political support
- Focused, unapologetic approach on objectives
- Targeted investment – ring fenced for cancer

NWIHP comparator

- Well developed strategy – although 21 months old
- Excellent Clinical Leadership
- Good clinical support, but as with NCCP not universal – work to be done
- DoH/HSE very supportive
- JCHC very supportive – volume of PQs indicative of scale of challenge

NWIHP comparator (2)

- Team focused solely on objective – this will create tension within hospitals/hospital groups and AHD
- Requires support from the HSE when singular focus conflicts with issues at hospital front doors
- Targeted investment ?????

2016 Developments

- Although NWIHP not in place until 2017, a lot was done in 2017
- Implementation of HIQA report on Portlaoise, which included DOM for all 19 hospitals/units
- Bereavement standards were launched and funding secured for all hospitals/units
- HIQA maternity standards developed and launched

2017 updates

- As the team developed all 19 visits have been visited
- Engagement with key stakeholders, getting support and understanding for the priorities
- Building our networks, speaking at events, and raising the profile
- Developing our operating model
- Completing the Implementation Plan

NMS Implementation Plan

- One of the primary task for NWIHP was to produce an implementation plan
- The NMS sets out that NWIHP will produce the plan within six months of the launch of the strategy
- As NWIHP didn't exist until 2017, the plan was submitted on 30th of June 2017 and launched in October

NMS Implementation Plan

- 77 Recommendations in NMS
  - 238 actions in implementation plan
- Actions focused across the four principles of
  - Health and Wellbeing approach
  - Clinically appropriate choice
  - Consistent, high quality, safe care
  - Governance and Leadership

Preparation

- Visit all 19 units (Letterkenny to Tralee)
- Engage with Group CEOs on governance
- Engage with midwifery , medical teams to get shared vision
- Build sense of momentum to a slow starting initiative
- Build confident in the political system around the role of NWIHP

Health and Wellbeing

- Healthy Ireland (2013-2025)core Government priority
- In maternity services it covers a wide range from pre-conception health through to post-natal complications
- Key for us it is about creating pathways to support women, and their families to maintain their health and wellbeing

Health and Wellbeing

- Perinatal mental health a key priority
  - New model developed by the Mental Health Directorate
  - Focus on early identification
  - Access to CMS in mental health, and to perinatal psychiatry (hub and spoke model)
- Breastfeeding
  - Key priority
- Bereavement and Trauma
- Smoking, Alcohol and Drugs
  - Identification
  - Appropriate pathways
  - Support and follow up

Health and Wellbeing - How

- Make Every Contact Count
- Bespoke training programme for all relevant maternity staff
- Create appropriate pathways
- Invest in key staff to enable pathways to work

Choice – Model of Care

- NMS has new model of care
- Three care pathways
  - Supported
  - Assisted
  - Specialised
- Key objective is to increase the number of women being offered, and accessing a supported care pathway

Choice – Model of Care

- Excellent examples around the 19 units, but no consistent approach
- Develop community midwifery capacity
- Build confidence with women

Choice – Model of Care

- Engagement with the DOMs around current configuration
- Identify locations where model is ready to start
- Use existing protocols for DOMINO like service as baseline
- 2018 focus on building capacity and providing access and choice for women

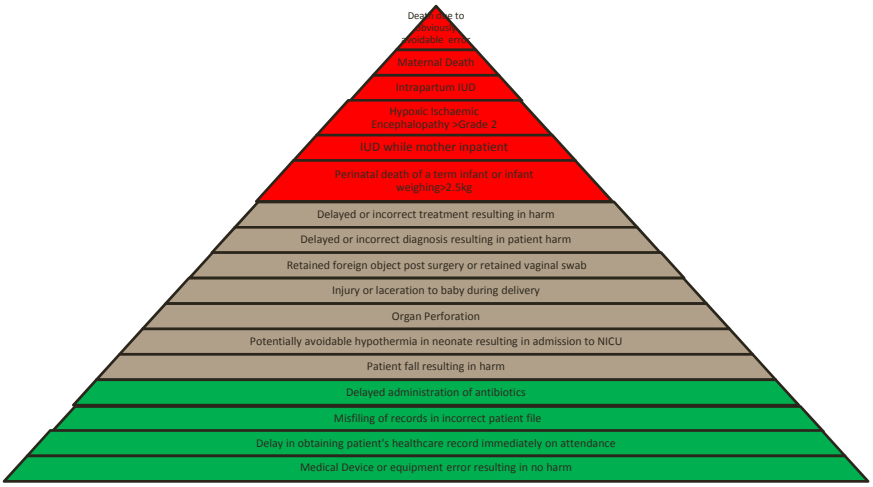
Consistent High Quality Care

- In parallel with Choice we need to improve the quality and how we handle adverse incidents
- Adverse outcomes in maternity have devastating consequence
- Recent history has undermined public confidence
- To build confidence around the new model of care, we need to better manage adverse incidents
- We need to improve learning and reduce pattern of errors

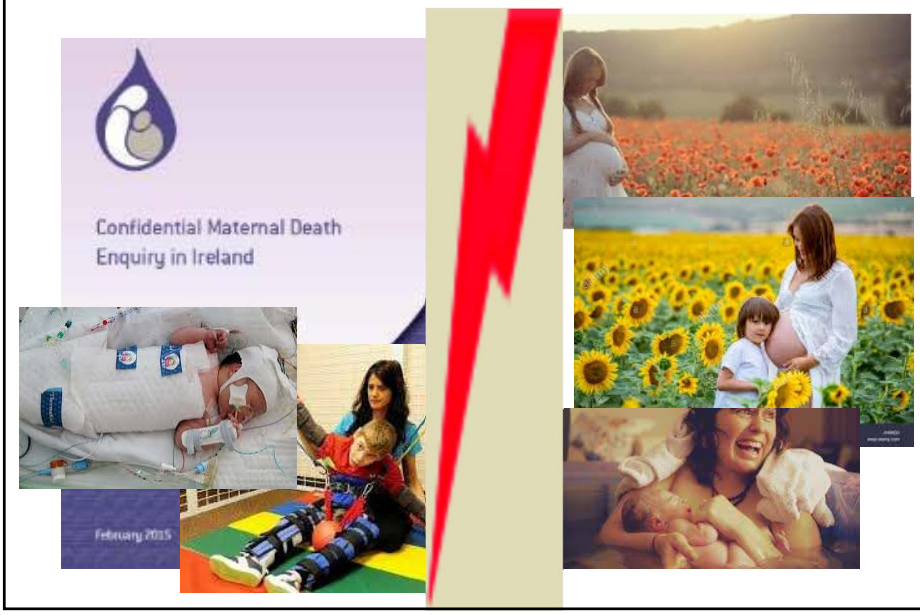
Consistent High Quality Care

- Most reviews have some combination of
  - Communications/escalation
  - Oxytocin
  - Instrumental Delivery
  - CTG interpretation
- Each Group to have obstetric only SIMF
- Each Group will have relevant clinical expert from another Group
- This will aid learning, and challenge tolerance levels

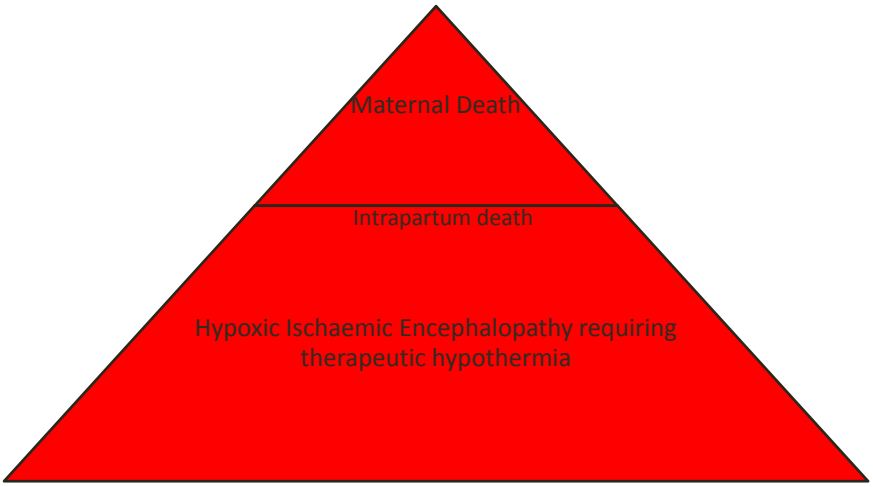
Serious Reportable Events



The Paradox



Where do we Start



How are we going to do it?

- These incidents notified to Hospital Group level
- Independent reviews, coordinated centrally
- Results amalgamated
- Findings disseminated

Governance and Leadership

- No uniformity to how maternity services are managed
- Well established model in Dublin Maternities, but not something that can be rolled out
- Maternity services in General Hospitals are not top priority (front door problems first), unless (or until) something goes wrong

Governance and Leadership

- Maternity Network to be established in each hospital group
- Midwifery lead, Clinical Lead, Quality and Patient Safety Lead, Business Manager and data analyst
- Maternity networks meet with their individual units monthly
- NWIHP meets each maternity network monthly

Governance and Leadership

- Structured engagement around
  - Agreed data set (Irish Maternity Indicator System)
  - Implementation Plan Update
  - Incident Review update
  - Benign Gynaecology
- Build management capacity in each network to support the approach
- Full visibility from Minister's desk to each labour ward

Policy Framework

- The National Maternity Strategy and the National Standard's when implemented represent necessary building blocks to providing a consistently safe, high –quality maternity service, which will in turn work towards restoring public confidence in the service.

Challenges

- Ever evolving landscape of HSE
  - Future health
  - Hospital Group
  - Slaintecare
  - Regional management structures
- Role of a National Programme versus Hospital Groups and CHOs
- Money

Funding

- 2018 funding request €14.6m
- Midwives
  - AMPs
  - CMS
  - CMM II
  - RMs
- Consultants – OBGYN, Psychiatry, Pathology
- HSCP – Ultra sonographers, Social Worker and Dietetics

Funding

- 10 year funding request > €75m (net of anaesthetics)
- Hugely ambitious plan, with high levels of recruitment over subsequent years
- Build a pipeline for future recruitment
- If funding comes, can we recruit?
- Large capital requirement of circa €1.2bn

Implementation Plan Rollout

- Rollout to each of 19 units
- Seek local buy-in for approach, and ownership for the plan
- Implementation happens in the hospitals and then the community, not HSE HQ
- Expectation has been developed, need the investment to support

Key Points

- Slow start but we are gathering momentum
- Ground work is done, foundations in place
- Engagement and investment are key
- How to deal with our “known unknowns”
- Succeed together or fail alone

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Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

VBAC:
exploding the myths with the OptiBIRTH study

Professor Cecily Begley
Chair of Nursing and Midwifery,
Trinity College Dublin
Ireland
and Visiting Professor, University of Gothenburg, Sweden

Trinity College Dublin

Vaginal Birth After Caesarean Section

OptiBirth

SEVENTH FRAMEWORK PROGRAMME

Acknowledgements

A big thank you to the women who took part
& **staff in the study sites,** particularly the **Midwife Opinion Leads and Obstetrician Opinion Leads**, the **researchers/post-doc researchers** in all countries and the OptiBIRTH team.

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The OptiBIRTH Team

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SEVENTH FRAMEWORK PROGRAMME

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Queen's University Belfast

UNIVERSITY OF EASTERN FINLAND

MHH Medizinische Hochschule Hannover

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entando

Why we did it - increasing CS rates

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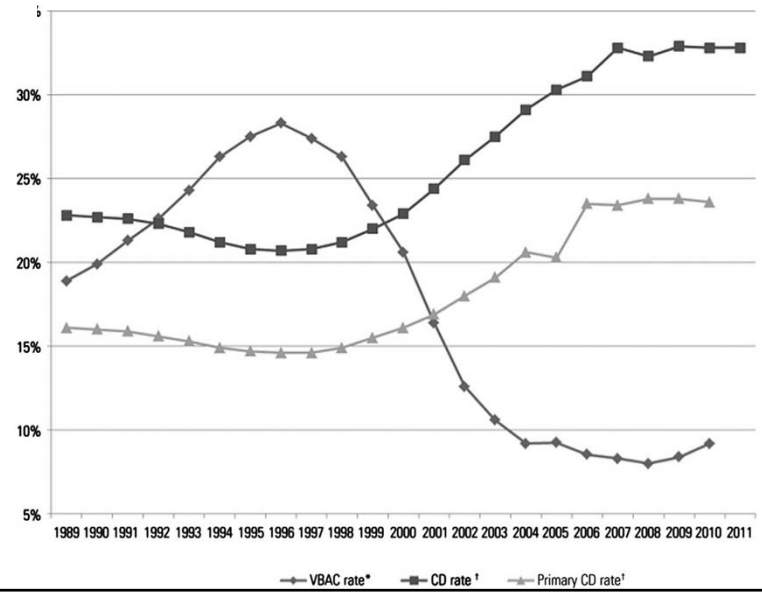

CS rate

Primary (First) CS rate

VBAC rate

Graph source: The American College of Obstetrician and Gynecologists (2014)
(U.S. National Centre for Health Statistics data)

Why we did it - CS rates across EU

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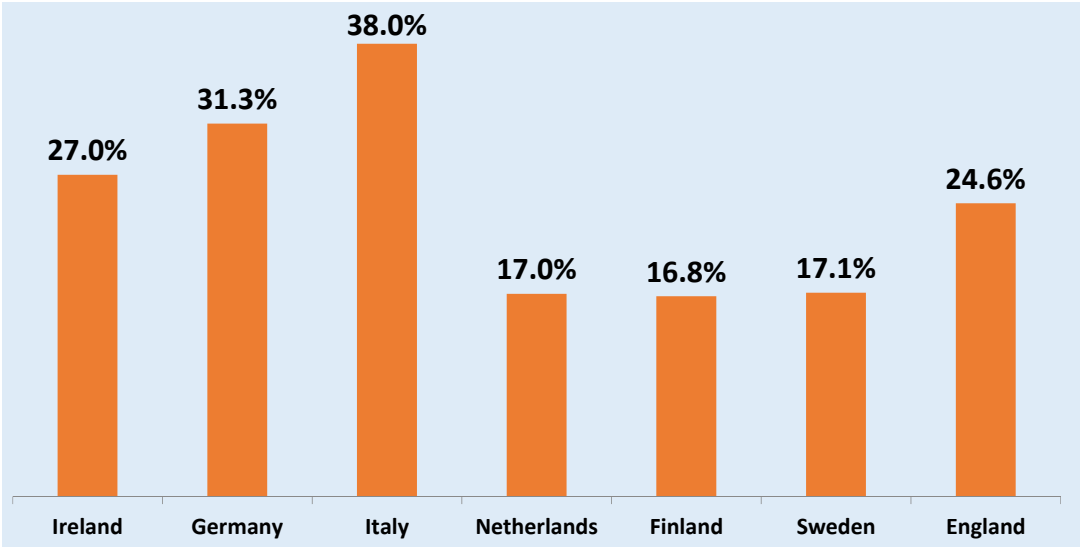

Reasons for increasing CS rates

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- **Several factors are likely contributing to the rise in overall CS rates, (fear of litigation, the perception that CS is a safe procedure, lack of awareness of its possible adverse consequences);**
- **Repeat CS following previous CS is a significant contributory factor, accounts for more than 1/3rd of all CSs in the US (Cheng et al, 2011) and 28% in the UK (RCOG, 2001)**
- **In Australia, the rate of repeat CS following previous CS is 83% (Laws et al, 2007) and almost 90% in the US (Hamilton et al, 2009)**

Repeat CS leads to increased morbidity

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A systematic review of 21 studies across the world, including over 2 million births (Marshall et al, 2011), showed that **maternal morbidity increases with increased number of previous CS:**

- Hysterectomy
  - more than 1 CS, OR 1.4-7.9
  - more than 2 CS, OR 3.8-18.6
- Blood transfusion
- Adhesions
- Surgical injury
- Placenta previa
  - OR 1.48-3.95
- Placenta accreta
  - OR 8.6-29.8 with more than 2 CS

Risk of uterine rupture

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- pVBAC: **0.47%** (CI 0.28–0.77) (Guise et al. 2010a)
- ERCS: **0.026%** (CI 0.009–0.082) (Guise et al. 2010a)
- Spontanous labour: **0.15%** (CI 0.11–0.32) (Dekker et al. 2010)
- Induction and augmentation: **0.54%** (CI 0.15–1.39) to **1.5%,** depending on mode of induction (Guise et al. 2010b, Dekker et al. 2010)
- Accounting for labour duration, induction is not associated with an increased risk of uterine rupture (Harper et al. 2012)

Other maternal morbidities

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Morbidity	pVBAC (95% CI)	ERCS (95% CI)
Hysterectomy (1*)	0.17% (0.12%-0.26%)	0.28% (0.12%-0.67%)
Haemorrhage (2)	OR 2.0 (1.5-2.6)	OR 2.5 (2.1-3.0)
Blood transfusion	0.9%	1.2%
Deep vein thrombosis (1)	0.04 %	0.1%
Hospital stay (in days) (1)	2.55(2.34-2.76)	3.92 (3.56-4.29)
Endometriosis (3)	Hazard ratio CS v Vaginal birth 1.8 (CI 1.7-1.9)	

*** Difference not significant; ** primiparas OR 4.08 (CI 3.16-5.28)**
1 Guise et al. 2010b; 2 Karlstroem et al. 2013; 3 Andolf et al. 2013

Maternal mortality rates

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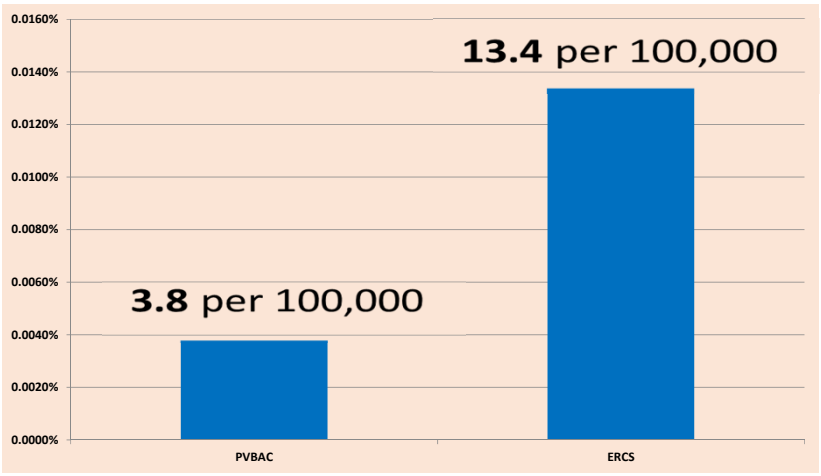

Guise et al. 2010a (203 studies)

Perinatal mortality rates

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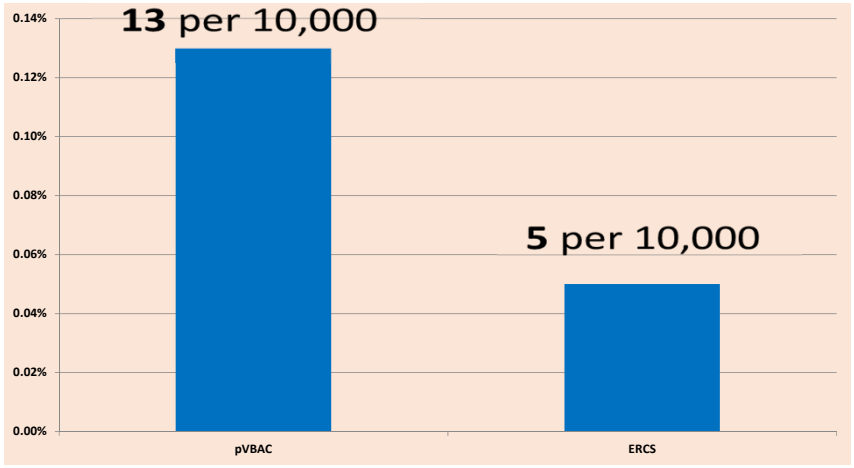

Guise et al. 2010a (203 studies)

Perinatal mortality rates

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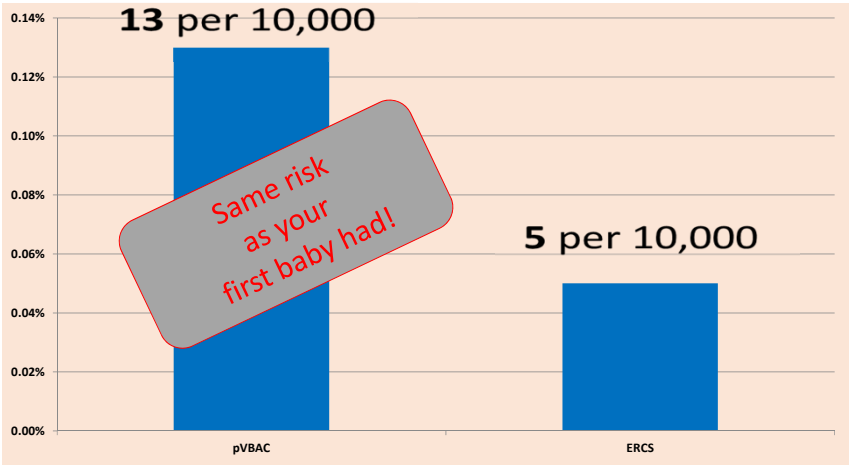

RCOG Birth after CS guideline (2007), and Smith GCS et al. 2002

Risks of planned VBAC

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For mother

- Higher risk of uterine rupture, although overall risk is low (1)
- Higher rates of repeat CS with induction (2)
- Increased morbidity in cases of pVBAC that end in unplanned CS (3)

For baby

- Higher mortality compared to ERCS (same as first baby) (1)
- No difference in morbidity, except in cases of pVBAC that end in unplanned CS - increased morbidity (3)

1 Guise et al. 2010a; 2 1 Shatz et al. 2013; 3 El-Sayed et al. 2007

Benefits of VBAC

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For mother

- Lower maternal mortality (1)
- Faster recovery (2)
- Experience of a vaginal birth as a significant life event
- Higher satisfaction with mode of birth (3)

For baby

- Lower risk for asthma (4)
- Lower risk of obesity in later life (5)

1 Guise et al. 2010a; 2 Kealy et al. 2010; 3 Shorten & Shorten 2012; 4 Tollanes et al. 2008; 5 Mesquita et al. 2013,

Other Findings

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	pVBAC	ERCS
Maternal satisfaction Scores	8.86/10	7.86/10
Breastfeeding initiation (1)	66.6%	58.7%
Edinburgh P/N depression scale (2)	Higher with C/S than vaginal birth	
Adapting to motherhood. (3)	Women after CS report experiencing more problems	
Expectations	With C/S some women experience feelings such as loss of control, a sense of failure as a woman and feeling different from other women. (4)	

1 Regan et al. 2013; 2 Shorten & Shorten 2012; 3 Weiss et al. 2009; 4 Fenwick et al. 2009

Conclusion

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Least Benefits & Most Risks

More Benefits & Less Risks than Emergency C Section

Most Benefits & Least Risks

Success rates – always around 75%

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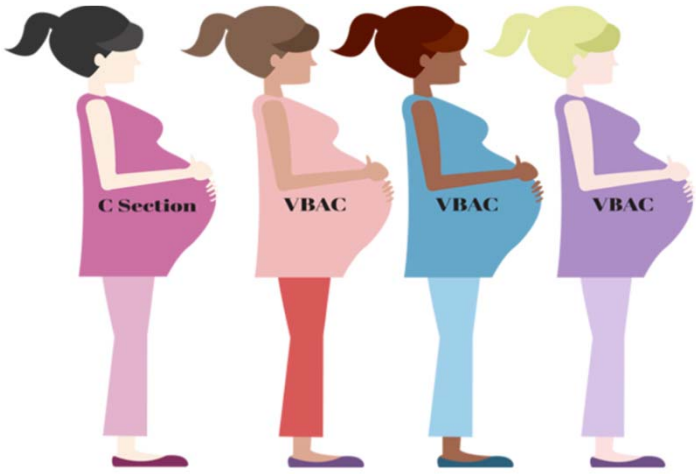

Success rates – 90%, if previous vaginal birth

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VBAC rates in Europe

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- VBAC rates in Ireland, Germany, and Italy are 29-36% (EURO-PERISTAT 2008).
- VBAC rates in the Netherlands, Sweden, and Finland are 45-55% (EURO-PERISTAT 2008).
- This difference results in an extra direct annual cost of €156m, based on Irish figures of CSs costing approximately €900 more than a vaginal birth (Begley et al 2011).

Aim

To improve maternal health service delivery, and optimise childbirth, by increasing vaginal birth after caesarean section (VBAC) through enhanced women-centred maternity care across Europe.

Gathering the evidence

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Two systematic reviews

- one on women-centred and
- one on clinician-centred interventions

Systematic reviews

- From the SRs we learned that our intervention should include:
- The use of **opinion-leaders** to lead care for women with previous CS
- The use of **decision-aids** and provision of **information programmes** for women

We conducted focus groups & individual interviews

To find out clinicians' and women's views on how to increase VBAC rates in both high and low VBAC rate countries

- High VBAC countries: **Finland, Sweden and the Netherlands**, 45%-55%
- Low VBAC countries: **Ireland, Germany and Italy**, 29%-36%

  (Euro-Peristat, 2008)

- A total of 115 clinicians and 71 women took part in the interviews

Women told us they need…

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- Realistic, consistent, factual VBAC information
- Confident and experienced clinicians
- Support to overcome a previous negative birth experience and fear of childbirth
- To be given confidence in giving birth vaginally

Clinicians told us we should…

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- Run specialised antenatal classes/meetings
- Encourage shared-decision-making around mode of birth
- Use birth plans
- Highlight the sense of accomplishment that can be achieved with a successful VBAC
- Develop a positive attitude towards VBAC from society and clinicians
- Give 'VBAC women' the same treatment and support as other women, but with some extra precautions

We designed the OptiBIRTH intervention

The whole team worked together on devising the intervention, with advice and assistance

from Beverley Beech, Association for Improvements in the Maternity Services (AIMS), UK.

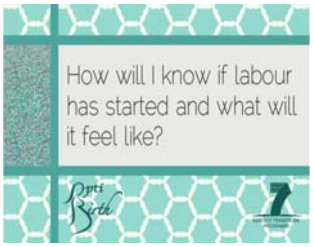
AIMS

We designed the OptiBIRTH intervention

A complex intervention consisting of five components:

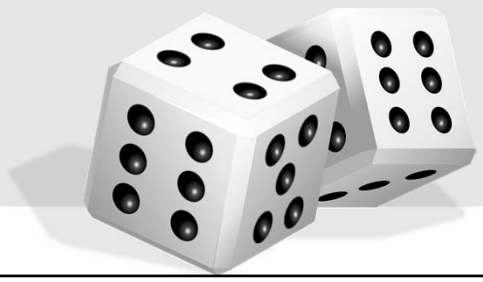
1. Midwife and obstetrician Opinion Leaders to promote and support VBAC
2. Educational/information sessions for women, using motivationally enhanced educational materials (2 x 2-hours)
3. A one-hour information session for all clinicians
4. Bringing women and clinicians together to discuss
5. Online resources for women and clinicians

We designed antenatal classes and leaflets for women



OptiBIRTH (the trial)

- Following ethical approval, we tested the intervention by conducting a cluster, randomised trial in Ireland, Germany and Italy, in a total of 15 hospitals with 120 women in each.
- In each country, 5 hospitals were randomly allocated to either have the intervention or (in the “control” groups) to have usual care.



Primary outcome

Site (I: intervention; C: control)	2012 (eligible births)	2012 (VBAC & % of eligible births)	2015 (eligible births)	2015 (VBAC & % of eligible births)	Change in %	Risk ratio [95% CI]
Trial as a whole (I)	2518		2682			

Primary outcome

Site (I: intervention; C: control)	2012 (eligible births)	2012 (VBAC & % of eligible births)	2015 (eligible births)	2015 (VBAC & % of eligible births)	Change in %	Risk ratio [95% CI]
Trial as a whole (I)	2518	645 (25.6)	2682	720 (26.8)	1.2	1.00 [0.91, 1.09]

Primary outcome

Site (I: intervention; C: control)	2012 (eligible births)	2012 (VBAC & % of eligible births)	2015 (eligible births)	2015 (VBAC & % of eligible births)	Change in %	Risk ratio [95% CI]
Trial as a whole (I)	2518	645 (25.6)	2682	720 (26.8)	1.2	1.00 [0.91, 1.09]
Trial as a whole (C)	3156	576 (18.3)	2853	567 (19.9)	1.6	1.09 [0.99, 1.21]

Comment

Overall, there was no significant difference in the change in the proportion of women having a VBAC between the intervention sites compared to the control sites

Primary outcome - Italy

Site (I: intervention; C: control)	2012 (eligible births)	2012 (VBAC & % of eligible births)	2015 (eligible births)	2015 (VBAC & % of eligible births)	Change in %	Risk ratio [95% CI]
Italy (I)	736	61 (8.3)	652	143 (21.9)	13.6	2.43 [1.84, 3.22]

Comment

There was a significant difference of 13.6% ($p<0.001$) in the intervention sites between the pre-trial rate of VBAC and the rate during the last year of the trial.

Outcomes for women

Uterine rupture (tearing of the uterus because of the previous scar)

- Two women had uterine ruptures (tears) in the main OptiBIRTH trial (1 in the intervention group and 1 in the control group)
- Uterine rupture rate of 1 per 1,000 women
- Both mothers and babies were healthy and well going home on day 4/5.

Outcomes for babies

Number of babies that died after 24 weeks gestation:

- 4 in the intervention group (0.34%) and
- 4 in the control group (0.51%)

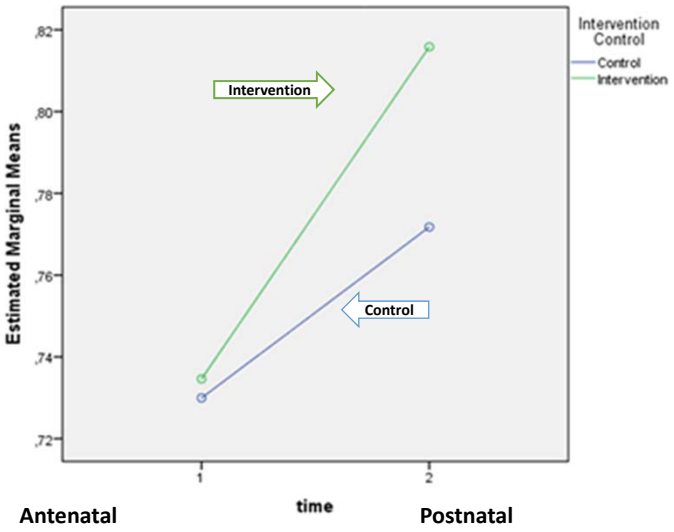
…a non-significant difference.

Outcomes for babies

- Admitted to the Neonatal Intensive Care Unit (of the live-born babies):
  - Intervention group: 90 babies out of 1163 (7.7%)
  - Control group: 63 babies out of 777 (8.1%)

  …a non-significant difference.

Quality of life (Ireland)



Summary

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- Our results showed **similar, and low, adverse maternal or neonatal outcomes** between women exposed to the OptiBIRTH intervention and those who were not; the intervention thus appears **feasible and safe,** and we will make it freely available to any unit or individual that requests it.
- The whole-trial results show no significant difference in VBAC rates in the intervention and control groups.
- The country-specific results appear to show that **the OptiBIRTH intervention may assist in supporting VBAC, especially in sites with very low VBAC rates**, but more time is needed for change to take place.
- **Women's quality of life is improved in the intervention sites.**

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Information resources

Below are documents relevant to the work of the OptiBIRTH project. There are also links to websites that may contain relevant information. We do not accept responsibility for the content of external websites

Attachments

- FP7 guidance notes for project reporting
- FP7 Financial Guidance
- FP7 Help avoid financial errors
- Lowdon G and Chippington Derrick D. VBAC – On Whose terms? AIMS Journal. Spring 2002. Vol. 14. No 1
- Lundgren et al. (2012) 'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section)
- Lundgren et al. (2015) Clinicians' views of factors of importance for improving the rate of VBAC (vaginal birth after caesarean section): a qualitative study from countries with high VBAC rates
- Lundgren et al. (2015) Clinician-centred interventions to increase vaginal birth after caesarean section (VBAC): a systematic review
- Gross et al. (2015) Interinstitutional variations in mode of birth after a previous caesarean section: a cross-sectional study in six German hospitals. J Perinat Med. 2015 Mar;43(2):177-84. doi:10.1515/jpm-2014-0108. PubMed PMID: 25395596
- Healy P. (2015) Healy P The challenges of complex research studies for participants, sites and researchers. 5th International Nursing and midwifery Conference. National University Ireland Galway NUIG. 30th April,1st May 2015
- Nilsson et al .(2015) Vaginal Birth After Cesarean: Views of Women From Countries With High VBAC Rates
- Clarke et al. (2015) Improving the organisation of maternal health service delivery and optimising childbirth by increasing vaginal birth after caesarean section through enhanced women-centred care (OptiBIRTH trial): study protocol

References and recommended reading

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FROM BULLYING YOU TO CARING FOR YOU

RCM/INMO CONFERENCE 12/10/17

Gill Adgie and Anne Wilson

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

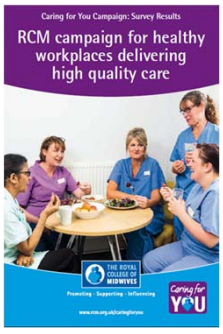
Caring For You Campaign

2

The RCM's Caring For You Campaign was in response to a survey carried out during March 2016 to gather information on the health, safety and wellbeing of our midwives, maternity support workers and student midwives at work.

The key findings of the survey were divided into six sections.

- Shift and Working Time.
- Work Intensification.
- Sickness Absence.
- Organisational Policies.
- **Workplace Culture, Bullying and Leadership.**
- Reporting Concerns.



Workplace , Bullying and Leadership

3

Survey Results

51% of respondents had received harassment, bullying or abuse from service users and/or their families.

31% of respondents had received harassment, bullying or abuse from managers.

33% of respondents had received harassment, bullying or abuse from colleagues.

37% of respondents who had suffered bullying, harassment and/or abuse did not report it.

Defining Bullying – No legal definition

4

"Bullying is repeated actions and practices that are directed to one or more workers, which are unwanted by the victim which may be deliberate or unconscious, but clearly cause humiliation, offence and distress and that may interfere with job/role performance and or cause an unpleasant working environment" (Einarsen 1999)

Einarsen S (1999) The Nature and Causes of Bullying at work. International Journal of Manpower-20(1/2): 16-27

The Law

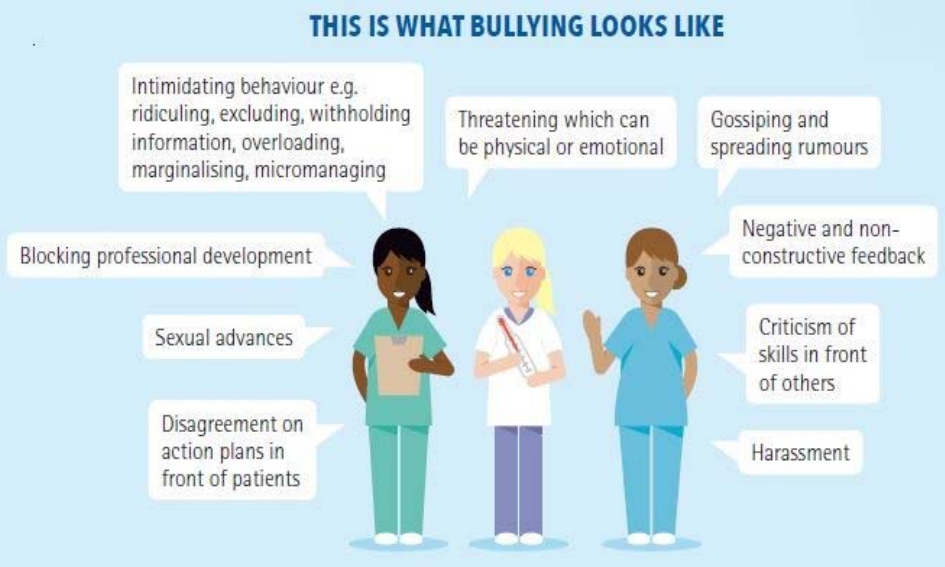
5

Bullying in itself is not against the law but harassment is when related to:

- Age
- Gender
- Disability
- Marriage and civil partnership
- Pregnancy
- Race
- Religion
- Sexual orientation

What does bullying look like in the workplace?

6



What does being bullied feel like ?

7

- **Ridiculed**
- **Excluded**
- **Information Withheld**
- **Overloading with information**
- **Intimidated**
- **Marginalised \ Micromanaged**
- **Threatened-Physical or emotional**
- **Gossiped about**
- **Blocking development**
- **Sexual advances**

What does it mean for Maternity Services?

8

- Increased risk of poor outcomes for women/patients
- Reduced opportunities to develop
- Increase in sickness
- Poor staff morale
- Poor professional Image
- Resignations

Why does it happen?

9

"Workplace bullying is about the bully seeking to remove power from you and keep it to themselves"

Aryanne Oade "Free yourself from Workplace bullying" (2015)

The power of culture

10

Who seems to be accepted and who doesn't?

What kind of behaviours get rewarded?

How is the culture reflected in the systems adopted by the unit?

What does management pay most attention to?

How are decisions made?

So what is it like where you work?

11

How often do you hear……..?

The labour ward is really busy – I'm bringing the her over, you'll have to sort it

What?? Another transfer from community/MLU you can't manage???

Oh - that's just her…….

What you can do

12

- Know yourself & the impact you have on others
  - Hold the mirror to yourself
- Ensure all views are taken into account
- Listen carefully and seek to understand
- Do not walk by when you see it happening-have courage to help and deal with it
- If you don't intervene the cycle will continue
- Lives will be destroyed

The Code

13

Promote professionalism and trust

You uphold the reputation of your profession at all times.

You should display a personal commitment to the standards of practice and behaviour set out in the Code.

You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

The Code

14

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect

and influence the behaviour of other people

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

RCM Campaign Charter.

15

1. Work in partnership with the RCM Health and Safety Representative to develop and implement an action plan about health, safety and wellbeing issues that are important to the maternity workforce and maternity service users.
2. Ensure that midwives and maternity support workers have access to a variety of shift patterns and flexible working and promote a positive workplace culture around working time including taking breaks.
3. **Foster a positive working environment for all by signing up to the RCM/RCOG statement of commitment calling for zero tolerance policy on undermining and bullying behaviours.**
4. Enable midwives and maternity support workers to access occupational health and other organisational policies for their mental and physical health, safety and wellbeing.
5. Nurture a compassionate and supportive workplace that cares for midwives and maternity support workers so that they can care for women and their families.

Undermining Behaviours and Bullying

16

Add RCM Video Undermining Behaviours and bullying. (3.5 mins)

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwishYTF5ZrWAhXiL8AKHZZZD0gQtwIILTAA&url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3De2wWiq_XFco&usg=AFQjCNGfzmJaFliRIUD5bgj8yhaeApQt-A

RCM- Undermining Behaviours.htm

For further information

Website: www.rcm.org.uk
Telephone: 0300 303 0444
Email: info@rcm.org.uk

www.facebook.com/midwivesRCM

@MidwivesRCM

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

ME AND MY HEALTH
MINDFULNESS: A TIME TO PAUSE

ANNE KIRWAN
CENTRE FOR MINDBODY INTEGRATION
ALL IRELAND MIDWIFERY CONFERENCE
12 OCTOBER 2017

WHAT IS MINDFULNESS?

- Historically found in all Traditions
- "Paying attention in a particular way: on purpose, in the present moment, and non-judgmentally." (**Kabat-Zinn**).
- **Mindfulness** also involves acceptance, meaning that we pay attention to our thoughts and feelings without judging them—without believing, for instance, that there's a "right" or "wrong" way to think or feel in a given moment.
- **Mindfulness** is a state of active, open attention on the present. When you're **mindful**, you carefully observe your thoughts and feelings without judging them good or bad.

THREE MINUTE BREATHING SPACE- INFORMAL PRACTICE

- Holding Intention and Attention
- Taking your seat- inviting the body to participate in the practice
- 3 minute breathing space-: A.G.E.
- **A**cknowledge what's here- body sensations, thoughts, emotions
- **G**ather attention towards the breath
- **E**xpand awareness of breath into the whole body

WHAT IS THE OPPOSITE TO MINDFULNESS?

- **Mindfulness** is the **opposite** of being "mindless" or on "automatic pilot."
- It's also the **opposite** of multitasking because it means being focused on just one thing in the moment.
- On automatic pilot we are more likely to have our buttons pressed- triggers old habitual habits and patterns of reacting rather than responding

WHAT IS STRESS?

- Simple definition: *Stress* results from any change you must adapt to..
- Stress is an everyday fact of life.
- You can't avoid it!
- Not all stress is Bad!
- Sources of stress: environment, social, physiological, psychological

- I get stressed when…
- When I get stressed I…

Take a moment to reflect, then in pairs

Large group Inquiry-

Research : Lazarus and Folkman(1984)

Appraisal of a situation: 1. event dangerous or not? 2. Can I cope or not?

WHAT IS STRESS? (CONT'D)

- Organism: moves away or towards a stimulus
- Pleasant..unpleasant..neutral
- Prefrontal cortex- the thinking and 'Noticing Brain'- perception
- Evolution of the Brain- Fight/ flight/ freeze (Triune Brain-Dr Paul MacLean)
- Autonomic Nervous system:
- Sympathetic and Parasympathetic Nervous systems, Polyvagal Theory- Dr Stephen Porges
- Window of Tolerance- Daniel Siegel- flipping your lid!
- Stretch Break

- Tend And Befriend- Caretaker Burnout!

Stress Response	Stress Response Turned Inward	Self Compassion
Fight	Self-criticism	Self- Kindness
Flight	Self- Isolation	Common Humanity
Freeze	Self- Absorption	Mindfulness

MINDFUL SELF COMPASSION- DR KRISTIN NEFF

- Threat- protection system
- Cortisol driven
- Pleasure –reward system
- Dopamine driven
- Caregiving – soothing- comfort system
- Oxytocin driven

- Dr. Paul Gilbert, *The Compassionate Mind*

SELF COMPASSION

THREE EMOTIONAL REGULATION SYSTEMS- DR. PAUL GILBERT

- Increases ability to cope with stress through greater awareness of stress reactions
- Boosts the immune system
- promotes a general sense of wellbeing, autonomy and satisfaction with life
- Enhances relationships
- Enhanced capacity to live with chronic pain or illness
- Increased vitality
- Increased capacity to modulate and tolerate emotions such as anxiety, anger, sadness, fatigue
- Aids sleep
- Beneficial changes occur in the chemical structure and functioning of the brain.

BENEFITS TO PRACTISING MINDFULNESS

MINDFULNESS BASED STRESS REDUCTION (MBSR)

- ***What is possible to practice and learn over the 8 week Mindfulness Based Stress Reduction Course?***

- **Gain an understanding** and awareness of the body, sensations and the breath from the inside out.
- **Developing this understanding** or felt sense in the body and breath so that you can be fully present in the moment to name and recognise old habitual patterns, habits and beliefs as they arise.
- **Sensing in the body** – improved self awareness of self and others, using the breath and body as a barometer to stay 'Here'.
  You can live in the body more than in your head!
- **Noticing thoughts**.. the practices enhance our ability to focus and pay attention, to recognise thought patterns that are habitual and can in fact cause spiralling into a low mood or intensify stress – Mindfulness practice invites us to choose where to place our attention and how much energy to give to stress intensifying thoughts.
- **Observing emotions**... allowing emotions to be more fully present, manageable, tolerable and integrated.

MBSR(CONT'D)

- **Increased ability to manage stress** more effectively by recognising your own stress reactions.
- **Exploring** this awareness by inviting and allowing your present moment experience... you may choose to respond in a different way to yourself and the world. New ways of relating to yourself, others and your place in the world.
- **Inviting more choice**: wiser decisions and wiser actions in your life.
- **Cultivating** a warm and friendly attitude... Invites and allows warmth, softening, soothing, allowing, deepening.
- **Invites being kinder and more compassionate to yourself**... not wanting to change things or wishing all the time things were different, fighting with yourself..driving and striving..allows space for being kind to yourself.
- **Accept yourself as you** are not as you wish to be.
- **Seeing the Extraordinary in the Ordinary in everyday life**.. noticing the beauty of the world around and in you.
- **More Presence to Self** so more present and available to those you are in relationship with – potential for better communication, engagement and connection in relationships, family and work.

FORMAL PRACTICE: THE BODY SCAN

- The body scan is a practice that encourages us to develop a greater intimacy with, and acceptance of ourselves, exactly as we are in this moment.
- We are exploring and developing a friendly interest and curiosity in our body, in sensations, and in the thoughts and feelings that may arise during the exercise.
- Everything that comes up during the body scan – whether it is restlessness, boredom, irritation, sleepiness – is welcome.
- Our job is simply to notice and to allow whatever arises to be there, with as much openness, curiosity and acceptance as possible....putting out the welcome mat for whatever arises.
- Can you be gentle with whatever arises as you practice?
- Can you keep turning up, even if you don't 'like' the practice or you find it challenging?

THE BODY SCAN (CONT'D)

- Mindful Inquiry
- Questions And Answers
- Closing:
- Minute of sitting- 3 breaths, poem, bell

Celebrating 10 years

AIMS

Association for Improvements in the Maternity Services - Ireland

Are you listening – Can you hear us?

Dr. Krysia Lynch AIMS Ireland

- You might say - "Of course I listen to women" .....
- I say ..... "mmmm"

You might be thinking ....

1. Provide information on evidenced based practices in birth
2. Provide support to women who have had poor experiences
3. Raise awareness of issues within the Irish Maternity Services
4. Represent consumers on National, Regional and Local hospital committees
5. Carry out consumer surveys
6. Campaign for the repeal of the 8th amendment
7. Liaise with other maternity groups

AIMSI – What do we do?

Informal contacts

- AIMSI queries and SM contacts 3,000 to 5,000 women on a daily basis

Formal contacts

- AMSI What Matters To You survey 2014 2832 respondents #WMTY2014

Other surveys

Public Consultation DoHC 2015

How do we know what women want? We ask.

- Safety
- Evidence based care
- Equity of care
- Good outcomes
- Information
- Choice
- Support
- A partner in decision making
- Individualised care not a factory based approach

What Women Want?


femail MAGAZINE 51

Home births safer? Rubbish. Mine nearly killed my baby

By Anna Wharton

EXPERT WHO SAYS: ONLY A HOSPITAL IS SAFE FOR MY DAUGHTER

One mum's terrifying story that challenges the latest edict by health watchdogs

THE MIDWIFE WHO INSISTS: HOME IS B


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

DELIVERY AFTER PREVIOUS CAESAREAN SECTION

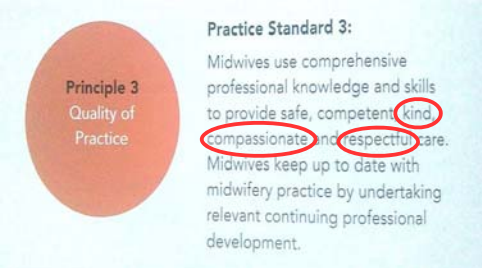
CLINICAL PRACTICE GUIDELINE

ans of Ireland

NHS

National Institute for Health and Clinical Excellence

- With Kindness
- With Respect
- With Dignity
- With Autonomy
- INDIVIDUALISED



- Can be more important than the outcome

How do women want to receive their care

- 1. One to one Personal listening
- 2. Listening in decision making – mutual trust mutual partnership
- 3. Listening to experiences
- 4. Listening in strategic terms – representation consultation
- 5. Acting on what you have heard

Listening comes in all sorts of shapes and sizes

- HCPs at the coal face – our needs in your care
- Unit Managers - when we are unhappy
- Hospital managers – enable us to evaluate our experience beyond excellent good fair poor
- Consultative committees - invite us on to share our experience and expertise
- Local Regional and National policy makers – ask us what worked well, what we think should change
- Act on what you have HEARD

Who do we want to listen?

- Routine vs choice
- Convenience vs hassle
- Does the buck stop with me?

Challenges to listening

- Requires time
- Requires skill
- Requires support

Challenges to active listening

- I formula fed all my babies and sure they are grand. One's training to be a lawyer
- First time mothers do better on an epidural
- Homebirth is dangerous
- Our hospital policy doesn't allow that
- Why spend another two weeks waiting? I d say go for the induction

Challenges to hearing - Personal prejudice

- **Before**: Questions, birth preferences, care model reassurance, information, choices
- **During labour**: Informed consent and refusal, birth preferences, evidence based care
- **Afterwards**: Experiences validated, support
- **Beyond birth**: Representation. Consultation Campaigning Challenging Partnership Trust

When we need to be heard

Use	Instead of
• OFFER	• GIVE
• INFORMED OPPORTUNITY	• ROUTINE POLICY
• PARTNERSHIP & TRUST	• CONTROL and COERCION

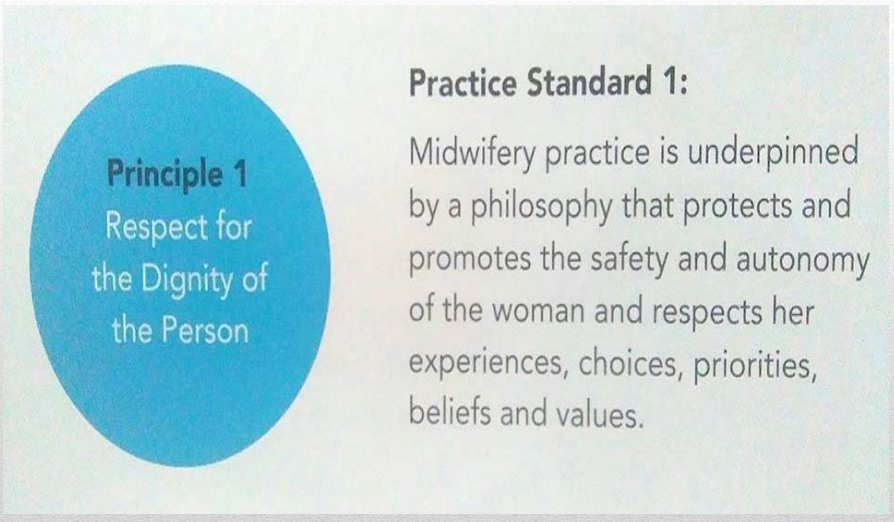
LANGUAGE

- Am I allowed to sit down, stand up, say no, speak, say yes, be naked, make a noise, ask questions, refuse, decide when and how I will give birth, have my baby skin to skin?
- Am I allowed to have a home birth?
- They won't allow you to go past 40 weeks
- You're only allowed one birth partner
- You're not allowed give birth on your hands and knees

Allow??

- Due dates – medical personnel decide
- Induction – medical personnel decide
- Sweeps – given routinely
- AROM – medical personnel decide
- Active Management of labour – given routinely
- Use of CTG – medical personnel decide
- Use of syntocinin – medical personnel decide
- Maternal position during labour and birth.....

INFORMED CONSENT : INFORMED REFUSAL



- **Implied Consent**
  - Consent was often implied but not sought by care providers.
  - "We are just going to help you get the placenta out now"
  - "We are just clamping the cord now"
- **Coercion**
  - Consent was sought but women were given no choice or information to refuse and sometimes felt pressurised to give consent.
  - Medical professional cites 'hospital policy' or accuses the mother of putting her baby at risk
  - "Its hospital policy to give syntocin for the placenta"
- **Complete Disregard of Consent**
  - The women were given no information or choice in the decision process and procedures were carried out specifically against mother's wishes or without even informing the women of what was happening.
  - Babies are given formula whilst mother is in recovery following C-birth

Categories of Lack of consent

WMTY2014 Consent, informed consent and informed refusal

	In pregnancy	In labour and birth	In pospartum
Consent was fully sought for all tests procedures and treatments	62.00%	67.70%	76.80%
Fully informed of potential benefits risks and potential outcomes of all tests procedures and treatments	56.60%	52.80%	60.80%
Were given the opportunity to make an informed refusal of a test procedure or treatment	48.90%	50.20%	57.00%

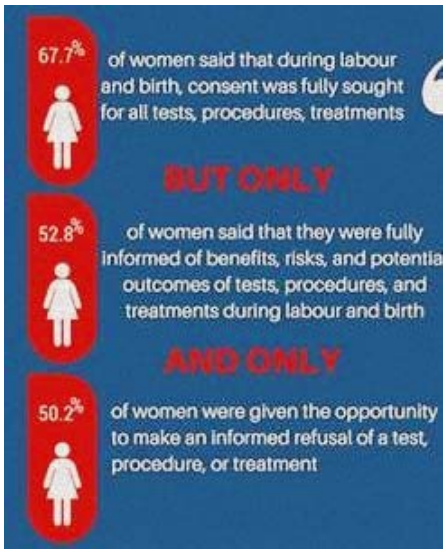
Consent

WHAT MATTERS TO YOU 2014 AIMSI SURVEY n=2832

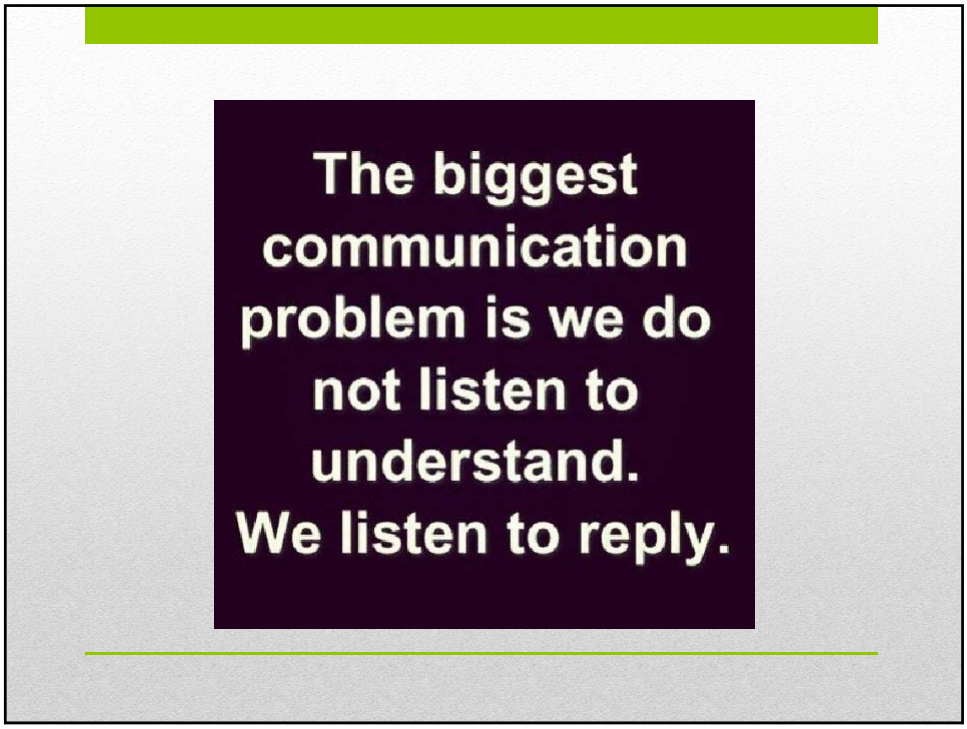
67.7%

52.8%

50.2%



50.2%



Women speak WMTY2014

- "Consent was sought at all times but I felt pressure that the only option was to agree with what was proposed."
- "Formally yes (consent was obtained), but I wasn't in favour of being induced, it was never presented as an option but rather as a decision made on my behalf."
- "Most things were not presented as a choice. "We have to do such and such" was the usual "choice."
- " I repeatedly impressed my wish not to have oxytocin and this was disregarded and I was treated like I was being silly. I reluctantly agreed but I felt badgered into submission rather than consenting."

Women speak WMTY2014

- "In the hospital and with the doctor unless I refused the procedure it was assumed that I would go ahead with it. I was told that it was happening, not asked if I wanted it to happen."
- "The tests they did were as far as I was told compulsory and results were just told to me and options were not discussed it was there way is best. When we questioned it we were told we were putting our babies life in danger."
- "I felt that I could not say no to anything. ."
- "I refused plenty, but they weren't put as questions. Statements like "we're just going to" or "ok, so now we'll" had to be responded to quickly with a NO, you won't, and that wasn't always "heard".

Ireland: Our National Consent Policy

- National Consent Policy
- 7.7.1 Refusal of treatment in pregnancy The consent of a pregnant woman is required for all health and social care interventions.
- However, because of the constitutional provisions on the right to life of the "unborn", there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.

A woman speaks WMTY2014

"Where to start? Women should be respected and listened to. We were treated like cattle, everyone is given the same appt time, you sit there for hours to be seen for less than a few minutes, if you ask questions you are made feel stupid, if you have a birth plan youre made feel like a hippy. There is no choice, its luck dependant on location. Its too easy to be disqualified for homebirth or MLU. There is no birth centre, I was not respected or listened to in labour with my second. I was told my birth plan was null and void as my ob wasnt working that night! I was laughed at by the dr when I asked for delayed cord clamping. My baby was taken away without my consent. I was offered no breastfeeding support. I was made to feel like a criminal for refusing the vit k. The list in endless."

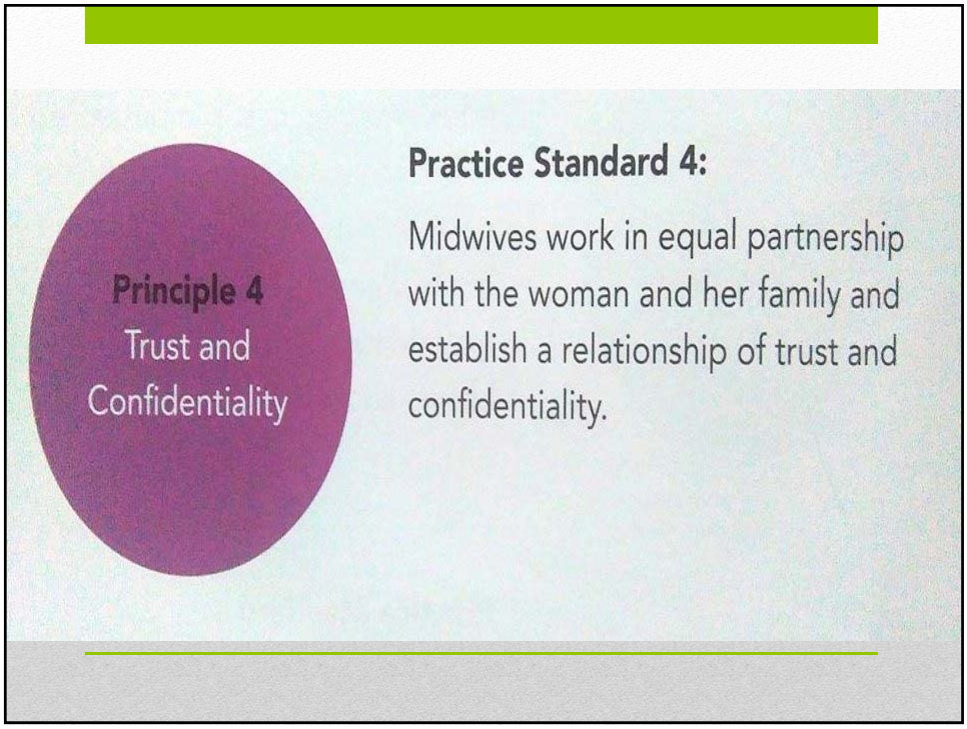
Women speak WMTY2014

"The midwife listened to me, examined me and brought be straight to the delivery suite. The midwives did the trace and talked through my birth plan. They flagged my request for a physiological 3rd stage and talked to me about the possible issues with my request. I listened and said I wanted to go ahead with it and they respected my wishes. In my birth plan, I said that I did not want to give birth on my back. My waters broke about 30 mins after I arrived in delivery suite and I was still having the trace. My midwife immediately took the trace off and strongly encouraged me to move into whatever position I wanted to use for birth. I felt respected and listened to from the minute I arrived at the hospital. It was pretty much perfect."

A woman speaks WMTY2014

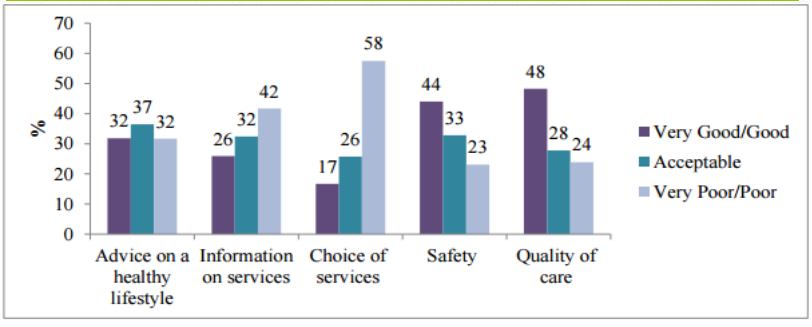
"I had a fabulous experience in NAME REMOVED, and while the midwives are stretched due the number of patients there, they were lovely and attentive, I never felt ignored or not listened to

Even though i was induced, had waters broken, put on a drip (all due to previous stillbirth). I made all of those decisions, decided when they would do things, how they did them. They listened carefully to me, and i was in total control of my birth (in a hospital)"



- Fear, Sub optimal experience
- Trauma
- Perinatal mental health problems
- We seek other avenues so that we can be heard
- PQs, Protests, Campaigns, The Media

What happens when we are not listened to?



Provision of information : POOR

Provision of choice: POOR

Provision of advice on healthy lifestyles : POOR (One third of respondents)

Quality of service: POOR (One quarter of respondents)

Safety of services: POOR (One quarter of respondents)

Rating of services 2015

- For **community** based care
- For **combined care** between the hospital AND community
- For **the home setting**

Strong preference 2015

The care provided by the homebirth midwives has been in my experience exceptionally good. Being heard, having the vagaries of your body respected, being attended in a non-medicalised situation by a woman entirely focused on you and your baby is beyond compare with the equivalent care in hospital (Service User)

For those, like myself, who have a normal pregnancy, and are lucky enough to be able to access a Community Midwife to avail of the homebirth service this service is incredibly good. The service in many ways is the polar opposite to what is normally received in the hospital setting in that one is given individual and specific care from a midwife(s) who have developed a relationship with you (both expectant mother & partner) (Service user)

NMS Consultation

I didn't have a say in how I wished my birth would go, I felt like I was a number and didn't matter..... I felt the consultants team members were dismissive of my feelings regarding their choices for me and felt like I was a puppet with no voice going through a first pregnancy is scary enough without being made feel like I had no control or say with anything that was to be done to my body. Communication needs to be improved greatly, a woman should be made feel part of the process not just an instrument in it! (Service user)

A number of respondents also stated that in their experience they were not afforded dignity and respect during their maternity care.

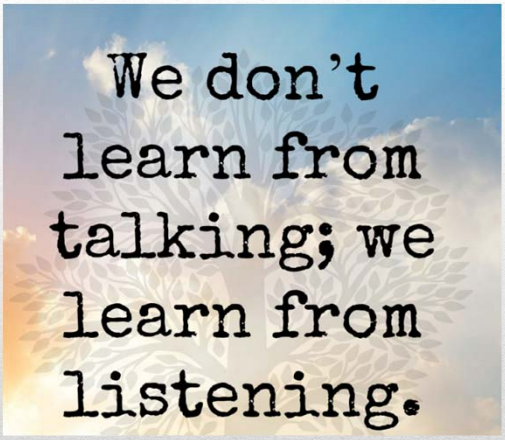
There is so little respect shown to women in Ireland during the process of birth which should be a happy occasion. You're just treated like a slab of meat in a hospital (Service user)

NMS Consultation

Are these the primary goals of the NMS?

ASK, LISTEN, TRUST, PARTNERSHIP

Here's Seana!



The word
LISTEN
contains
the same letters
as the word
SILENT.

— Alfred Brendel

Maintaining confidence in changing times: lessons learnt from the Lancet Series on the value of midwifery

RCM INMO conference
Armagh October 2017
Actions speak louder than strategies

Professor Mary Renfrew RM PhD FRSE
Mother and Infant Research Unit

University of Dundee

@midwiferyaction #LancetMidwifery
@maryrenfrew

THE LANCET

June, 2014 www.thelancet.com

'Midwifery is a vital solution to the challenges of providing high quality maternal and newborn care for all women and infants in all countries'

'Midwives are the single most important cadre for preventing maternal, neonatal deaths and stillbirths'

Healthy Newborn Network, Washington DC 2015

'The Lancet Series on Midwifery is pivotal in not just valuing midwifery, but also strategically positioning midwives as integral for achieving health care reform and global stability'

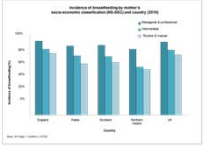
Davidson 2015, Midwifery 31 (2) 1119-1120

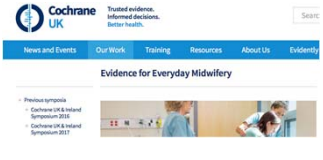
Maintaining confidence in changing times

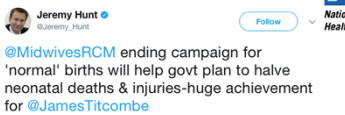
- What is the Lancet Series on Midwifery?
- What does it tell us about the value of midwifery?
- What difference has it made?
- How can it help us in changing times?

Midwifery: the changing context

The Report of the Morecambe Bay Investigation







Dichotomies and disconnects

Mortality	versus	health and well-being
Women	versus	children
Interventions	versus	normality, care
High income	versus	middle & low-income
Birth	versus	continuum
High	versus	low risk
Safety	versus	choice

The Lancet Series on Midwifery

- Series of 5 papers 2014-2016
- Aim to inform decision-makers on impact of midwifery in low-, middle-, high-income countries

Global challenges

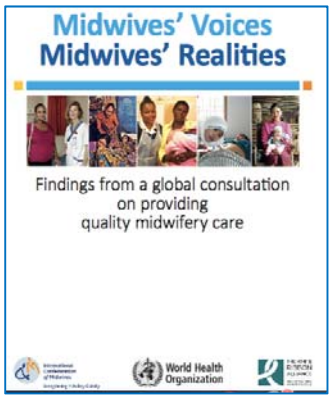
- 2.6 million stillbirths
- 2.9 million neonatal deaths
- 20 million+ women with serious morbidity

Global challenges

Of course we need lives to be saved….
but we also need lives to be lived

- 138 million women, 136 million infants, survive
- Longer term and psycho-social outcomes overlooked
- Unsustainably high rates of unnecessary interventions
- Inequalities in outcomes and care
- Care and compassion seen as less important - yet integral to system failures
- Disrespect and abuse of women and children in the health system
- Disconnect between evidence, policy, and practice
- Midwifery – essential yet contested

Midwifery – essential yet contested



- 37% experienced harassment at work
  - including fear of violence, insecurity
- 58% felt they are treated with respect
- 20% depend on another source of income
- 45% reported being exhausted

Filby A, McConville F, Portela A (2016) What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. PLoS ONE 11(5): e0153391.

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Supported by Bill & Melinda Gates Foundation and NORAD

Evidence base for new standard of care

The Lancet Series on Midwifery in a nutshell

Papers 2014 & 2016	Methods	Findings and conclusions
1. Midwifery and quality care	Defined midwifery, critical synthesis of quantitative and qualitative evidence, case studies	Could improve 50+ outcomes. Definition and framework for use in planning, monitoring, regulation, education
2. Projected effect of scaling up midwifery	Modelled impact of implementation of midwifery	Universal provision of midwifery as defined in the series could reduce mortality by 80%+
3. Country experience of strengthening health systems through midwifery	Analysis of four country case studies with high maternal mortality	Focus on coverage not enough. Must include quality, respectful care, reducing over-medicalisation
4. Improvement of MNH through midwifery	Summary, analysis, call to action	Midwifery and midwives crucial to achievement of national and international goals and targets
5. Asking different questions	Analysis and consultation to identify priority research questions	Priorities identified. Requires new programmes of research

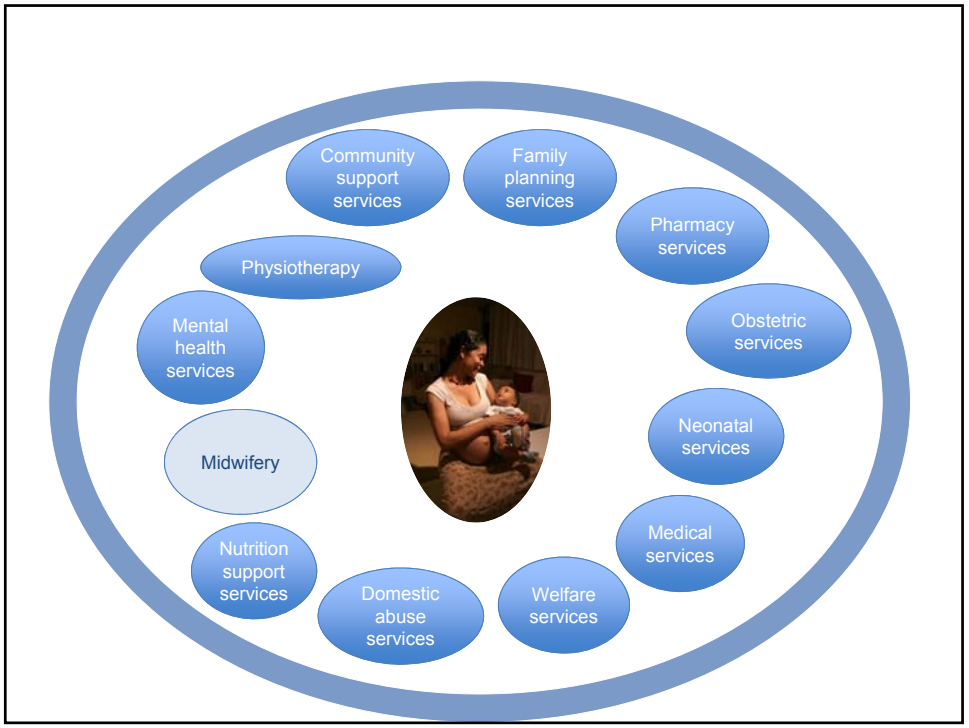
What is midwifery?

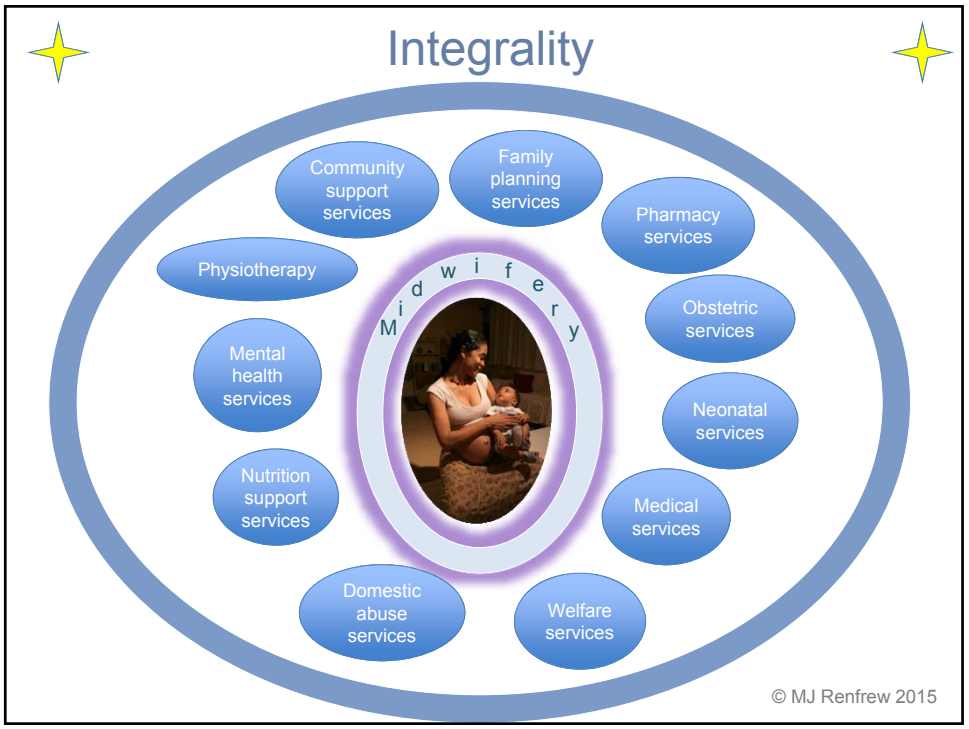
What, how, who, where?





First, start with women and babies


Community support services
Family planning services
Pharmacy services
Physiotherapy
Mental health services
Obstetric services
Neonatal services
Midwifery
Medical services
Nutrition support services
Domestic abuse services
Welfare services


Integrality
Community support services
Family planning services
Pharmacy services
Physiotherapy
Midwifery
Obstetric services
Mental health services
Neonatal services
Nutrition support services
Medical services
Domestic abuse services
Welfare services
© MJ Renfrew 2015

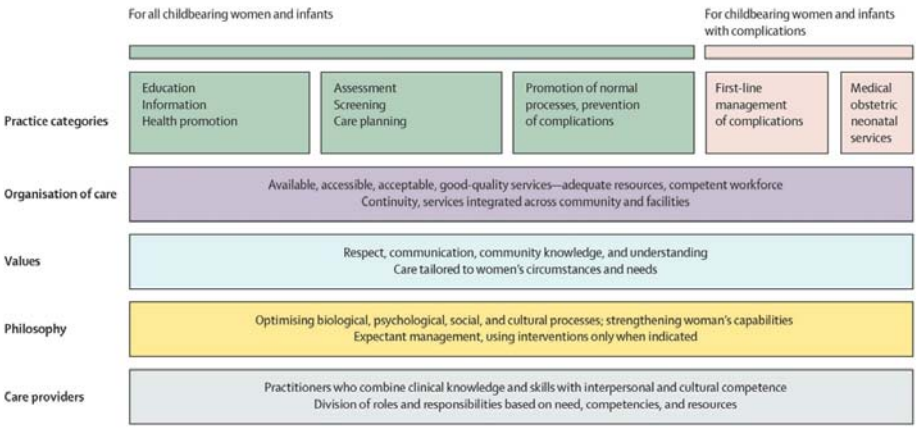
Defining midwifery

'Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life.

Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families'.

Renfrew, McFadden, Bastos et al The Lancet 384, I9948, 1129 – 1145, 2014

Framework for quality maternal and newborn care



Renfrew, McFadden, Bastos et al The Lancet 384, I9948, 1129 – 1145, 2014

Framework for quality maternal and newborn care
Lancet Series on Midwifery

FOR ALL CHILDBEARING WOMEN AND INFANTS

FOR ALL CHILDBEARING WOMEN AND INFANTS

Framework for quality maternal and newborn care
Lancet Series on Midwifery

FOR ALL CHILDBEARING WOMEN AND INFANTS

FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

Framework for quality maternal and newborn care
Lancet Series on Midwifery

Education Information Health promotion

Assess-ment Screening Care planning

Promotion of normal processes prevention of complications

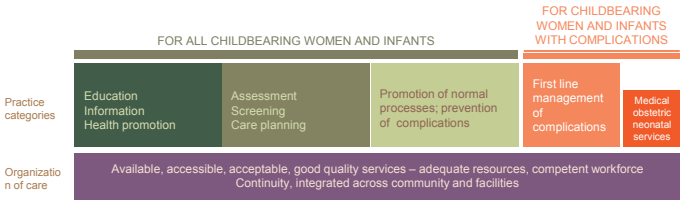
Framework for quality maternal and newborn care
Lancet Series on Midwifery

First line management of complications

Framework for quality maternal and newborn care
Lancet Series on Midwifery

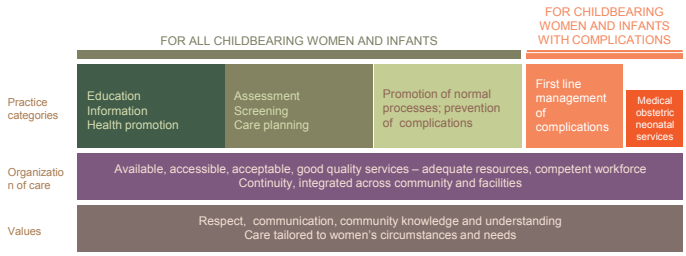
Medical obstetric neonatal services

Framework for quality maternal and newborn care
Lancet Series on Midwifery

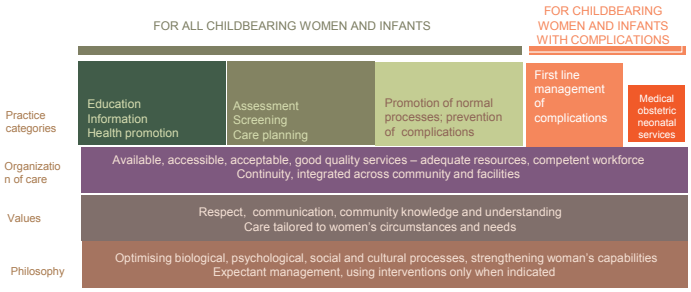


Available, accessible, acceptable, good quality services – adequate resources, competent workforce
Continuity, integrated across community and facilities

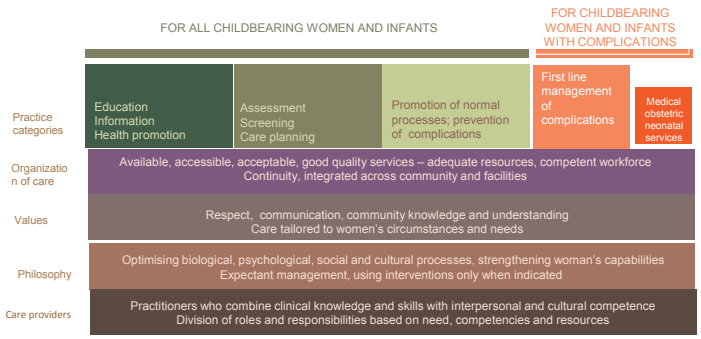
Framework for quality maternal and newborn care
Lancet Series on Midwifery



Respect, communication, community knowledge and understanding
Care tailored to women's circumstances and needs



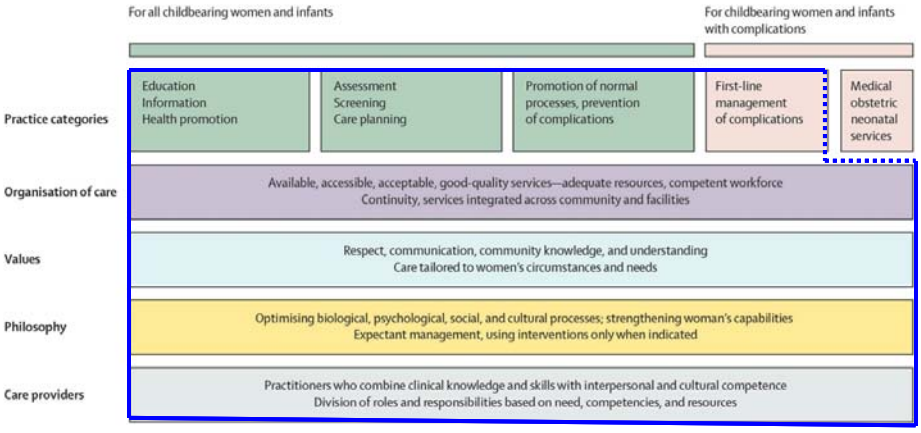
Optimising biological, psychological, social and cultural processes, strengthening woman's capabilities
Expectant management, using interventions only when indicated



Practitioners who combine clinical knowledge and skills with interpersonal and cultural competence
Division of roles and responsibilities based on need, competencies and resources

Framework for quality maternal and newborn care

Scope of midwifery



Renfrew, McFadden, Bastos et al The Lancet 384, I9948, 1129 – 1145, 2014

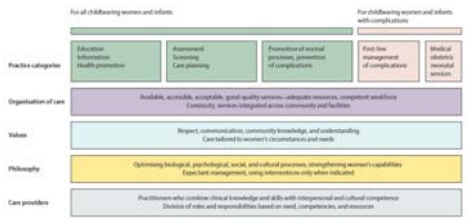
Midwifery's impact is huge

- 56 outcomes improved by midwifery
  - Maternal and newborn mortality, stillbirth reduced
  - Less preterm birth, low birthweight
  - Maternal morbidity reduced
  - Reduced interventions in labour
  - Improved psycho-social outcomes
  - Increased breastfeeding initiation and duration
  - Shorter hospital stays, improved referrals, increased attendance by known midwife
- Universal implementation of midwifery could reduce maternal newborn mortality and stillbirth by over 80%

Homer, Friberg, Bastos Dias et al The Lancet 384, 1146-1157 2014
Renfrew, McFadden, Bastos et al The Lancet 384, 1129 – 1145, 2014

It's not just what we do, it's how we do it…

- Skilled and compassionate care for all
- Preventive and supportive care throughout – not just birth
- Continuity, respect, understanding
- Normality
- Interdisciplinary working, embedded in the system – partnership is critical



Midwifery brings balance to the system

Mortality	and	health and well-being
Women	and	children
Interventions	and	normality, care
High income	and	middle & low-income
Birth	and	continuum
High	and	low risk
Safety	and	choice

Midwives are essential

'Midwifery was associated with more efficient use of resources and improved outcomes

when provided by midwives who were educated, trained, licensed, and regulated…..

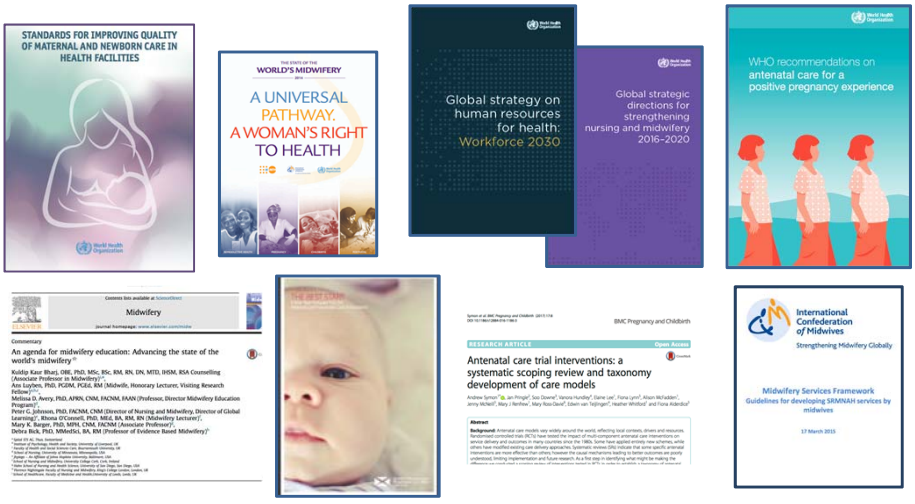
There are few benefits from relying on less-skilled healthcare workers.'

LSM paper 1

Evidence for a new standard of care

The Lancet Series on Midwifery

Influencing policy, education, system planning, research, workforce....



Improving services in Warrington & Halton Hospitals, UK

New model of care based on LSM framework for quality maternal and newborn care

Breaking down boundaries between acute & community care

Structure reflects woman's journey

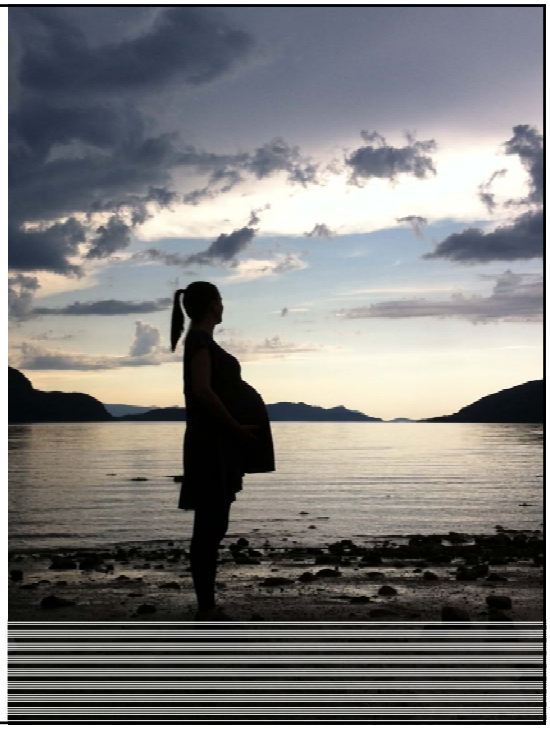
Kindness and compassion

Saving midwives in public health in New York City

- Financial crisis - cuts threatening midwifery services and education
- Action and public engagement informed by LSM evidence

Shaping midwifery curriculum in Sweden

'helps ensure that midwifery education covers all the elements of quality care'



Informing the curriculum in Bangladesh

'The curriculum for midwives is aligned with the LSM framework for quality maternal and newborn care'

Influencing perspectives on human rights, advocacy and action in India

WHO South East Asia region

All countries working together to develop their first national plans for midwifery as a result of LSM evidence

WHO Africa region

Malawi, Ghana, Zambia, Zimbabwe, South Africa, Tanzania

'LSM is a resource mobilisation tool used by governments, development partners, and education institutions to inform

- National policy direction
- Development of direct entry programs
- Regulatory bodies renewed commitment to midwifery'

Influencing research priorities, analysis, design

Asking different questions: research priorities to improve the quality of care for every woman, every child

Unacceptably high rates of adverse outcomes persist for childbearing women and infants, including maternal and newborn mortality, stillbirth, and short-term and long-term morbidity.[1] In light of the challenges to achieve the UN Sustainable Development Goals, it is timely to reconsider priorities for research in maternal and newborn health. Are we asking the right questions?[2] Recent evidence indicates the importance of seeking knowledge beyond the treatment of complications, to inform better ways of providing sustainable, high quality care, including preventing problems before they occur.[3]

by *whom*.[4] These are concepts that are often confused or ignored in existing studies. Midwifery was identified as a cost-effective and fundamentally important element

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Symon *et al. BMC Pregnancy and Childbirth* (2017) 17:8 DOI 10.1186/s12884-016-1186-3

BMC Pregnancy and Childbirth

RESEARCH ARTICLE Open Access

Antenatal care trial interventions: a systematic scoping review and taxonomy development of care models

Andrew Symon[1*], Jan Pringle[2], Soo Downe[3], Vanora Hundley[4], Elaine Lee[1], Fiona Lynn[5], Alison McFadden[1], Jenny McNeill[5], Mary J Renfrew[1], Mary Ross-Davie[6], Edwin van Teijlingen[4], Heather Whitford[1] and Fiona Alderdice[5]

Abstract

Background: Antenatal care models vary widely around the world, reflecting local contexts, drivers and resources. Randomised controlled trials (RCTs) have tested the impact of multi-component antenatal care interventions on service delivery and outcomes in many countries since the 1980s. Some have applied entirely new schemes, while others have modified existing care delivery approaches. Systematic reviews (SRs) indicate that some specific antenatal interventions are more effective than others; however the causal mechanisms leading to better outcomes are poorly understood, limiting implementation and future research. As a first step in identifying what might be making the

Transforming midwifery education

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Commentary

An agenda for midwifery education: Advancing the state of the world's midwifery ☆

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Partnership working

ICM
WHO
UNFPA
Unicef
White Ribbon Alliance
USAID
JHPIEGO
DfID
SIDA
Governments
Professional associations
Universities

Strategies into action

Thank you!

With thanks to all the mothers, babies, fathers, families and colleagues who contributed to this work
The Bill & Melinda Gates Foundation and NORAD

@midwiferyaction
#LancetMidwifery

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