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

Maternity Strategies for Ireland

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

CREATING A BETTER FUTURE TOGETHER
National Maternity Strategy Scotland
Action = Implementation

How are we doing?

Review of A Strategy for Maternity Care in Northern Ireland (2012-18)
March 2017
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’

IF YOU DO WHAT YOU ALWAYS DID, YOU WILL GET WHAT YOU ALWAYS GOT.
ALBERT EINSTEIN
Change

- Doing things differently
- Leadership

"If you think you’re leading but no one is following, then you are only taking a walk."

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
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.

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
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)

HSC Collective Leadership Strategy

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

[Draft September 2017]
• 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’

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 debates

5. Boundarlessness
   Encourage and practice systems thinking and collaboration across boundaries
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

Florence Nightingale

“The very first requirement in a hospital is that it should do the sick no harm.”
— Florence Nightingale
## 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

## 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
Person Centred Practice Framework  
(McCormack & McCance 2017)
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

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/
Global Professions

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.

NURSES AND MIDWIVES
A vital resource for health in the WHO European Region

Nurses and midwives play key roles in all aspects of health care and in society’s efforts to tackle public health challenges.

Growing and changing health needs raise challenges for nurses and midwives.
- Ageing populations
- Economic pressures
- Workforce shortages
- Health inequalities

Strategies for strengthening nursing and midwifery towards Health 2020 goals
- Scale up and translate education
- Plan workforce and optimise skill mix
- Create positive work environments
- Promote evidence-based practice and innovation

Nurses and midwives improve people’s health and well-being and reduce health inequalities.

http://www.nursingmidwifery.org
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

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”
“Change is the law of life. And those who look only to the past or present are certain to miss the future.”

~ John F. Kennedy

Midwives (Ireland) Act 1918

100 year Anniversary in 2018 – what is your story?
Then (1918 onwards)

And now... Our future
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

Midwives
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
Enjoy the rest of today’s conference
All Ireland Annual Midwifery Conference
Armagh City Hotel

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

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
Outcomes Based Accountability

Key Questions:

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

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
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**

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**Regional Transfer Process**

<table>
<thead>
<tr>
<th>Women's Details/ticker</th>
<th>Date and Time of Arrival</th>
<th>Name and Contact Details of Authorized Person</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nick</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hand number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
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</tbody>
</table>

**Demographic**

<table>
<thead>
<tr>
<th>No. of women</th>
<th>Age</th>
<th>Others</th>
<th>Non-ethnic origin</th>
<th>Regional birth</th>
<th>C/S birth</th>
</tr>
</thead>
</table>

**Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No</th>
<th>Yes</th>
<th>Unknown</th>
</tr>
</thead>
</table>

**Reason for Transfer**

- **Indication**
  - [ ] Non-contraception
  - [ ] Maternal medical
  - [ ] Congenital anomaly
  - [ ] Illness of mother
  - [ ] Other

**Local Authority**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>City</th>
<th>Region</th>
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**Support for women, babies & families**

**Support for professional practice**

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**Induction of Labour**

Information for pregnant women, their partners and families.

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**HSC Public Health Agency**

*Improving Your Health and Wellbeing*
Feeling your baby move is a sign they are well.

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, swoosh or roll. The type of movement may change as your pregnancy progresses. If you notice 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 are no set numbers of movements. Your baby will have their own pattern of movements, especially towards the end of pregnancy. The pattern may be different at different stages.

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

Why are my baby’s movements important?

A reduction in your baby’s movements may sometimes be an important warning sign that your baby is experiencing problems. A small number of women who have had a stillbirth noticed their baby’s movements had slowed down before the baby died.

Do not use any hand-held monitors, Dopplers or phone apps to check your baby’s heartbeat. Even a heartbeat, this does not mean your baby is alive.

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 your midwife or doctor as soon as possible. It is not possible to tell how many times your baby is moving from just one check-up.

If you think your baby is in any difficulty, you should call 111 or contact your local midwife or doctor as soon as possible. If you are worried about your baby being breathing, this does not mean your baby is not alive. Even if your baby is breathing, it may be weak. But worry about breathing, no matter how many times this happens.

NEVER HESITATE TO CONTACT

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

Low Risk
- No known risk factors

Increased Risk: one or more of the following:
1. Maternal Risk Factors
   - Maternal age > 35 years
   - Drug use (e.g. smoking)
   - Obesity
2. Previous history of a baby in the past
3. Recent history of a baby in the past
4. Maternal conditions: diabetes, hypertension, etc.

High Risk Care
- High risk factors: one or more of the following:
  - Maternal history of diabetes, hypertension, etc.
  - Previous stillbirth or baby death
  - Maternal complications: preeclampsia, abruptio placentae
  - Maternal conditions: diabetes, hypertension, etc.

Normal
- Normal growth or development

One or more risk factors
- Refer for further assessment and management by a specialist.

No risk factors
- Continue with normal care.

Screening and Surveillance of fetal growth in singleton pregnancies

HSC Public Health Agency
Improving Your Health and Wellbeing
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
RQIA Review of Maternity Strategy Implementation (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

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
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
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

- Health & Wellbeing
- Safe, quality & women-centred care
- Choice
- Resources, governance and leadership

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
One of the primary tasks 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.

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

Maternal Death

Intrapartum death

Hypoxic Ischaemic Encephalopathy requiring therapeutic hypothermia
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
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
<table>
<thead>
<tr>
<th>Implementation Plan Rollout</th>
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<tbody>
<tr>
<td>• Rollout to each of 19 units</td>
</tr>
<tr>
<td>• Seek local buy-in for approach, and ownership for the plan</td>
</tr>
<tr>
<td>• Implementation happens in the hospitals and then the community, not HSE HQ</td>
</tr>
<tr>
<td>• Expectation has been developed, need the investment to support</td>
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<table>
<thead>
<tr>
<th>Key Points</th>
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<tbody>
<tr>
<td>• Slow start but we are gathering momentum</td>
</tr>
<tr>
<td>• Ground work is done, foundations in place</td>
</tr>
<tr>
<td>• Engagement and investment are key</td>
</tr>
<tr>
<td>• How to deal with our “known unknowns”</td>
</tr>
<tr>
<td>• Succeed together or fail alone</td>
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</tbody>
</table>
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

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.

The research leading to these results has received funding from the European Union’s Seventh Framework Programme (FP7/2007-2013) under grant agreement no. 305208

The OptiBIRTH Team

Trinity College Dublin
Why we did it - increasing CS rates

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

Trinity College Dublin
Reasons for increasing CS rates

• 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

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

• pVBAC: 0.47% (CI 0.28–0.77) (Guise et al. 2010a)

• ERCS: 0.026% (CI 0.009–0.082) (Guise et al. 2010a)

• Spontaneous 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

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

* 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

Guise et al. 2010a (203 studies)

Perinatal mortality rates

Guise et al. 2010a (203 studies)
Risks of planned VBAC

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 Shatz et al. 2013; 3 El-Sayed et al. 2007
Benefits of VBAC

**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,

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Other Findings

<table>
<thead>
<tr>
<th></th>
<th>pVBAC</th>
<th>ERCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal satisfaction Scores</td>
<td>8.86/10</td>
<td>7.86/10</td>
</tr>
<tr>
<td>Breastfeeding initiation (1)</td>
<td>66.6%</td>
<td>58.7%</td>
</tr>
<tr>
<td>Edinburgh P/N depression scale (2)</td>
<td>Higher with C/S than vaginal birth</td>
<td></td>
</tr>
<tr>
<td>Adapting to motherhood. (3)</td>
<td>Women after CS report experiencing more problems</td>
<td></td>
</tr>
<tr>
<td>Expectations</td>
<td>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)</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion

- Least Benefits & Most Risks
- More Benefits & Less Risks than Emergency C Section
- Most Benefits & Least Risks

Success rates – always around 75%
Success rates – 90%, if previous vaginal birth

- 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

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...

- 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...

- 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.

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

<table>
<thead>
<tr>
<th>Site (I: intervention; C: control)</th>
<th>2012 (eligible births)</th>
<th>2012 (VBAC &amp; % of eligible births)</th>
<th>2015 (eligible births)</th>
<th>2015 (VBAC &amp; % of eligible births)</th>
<th>Change in %</th>
<th>Risk ratio [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial as a whole (I)</td>
<td>2518</td>
<td></td>
<td>2682</td>
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### Primary outcome

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<th>Change in %</th>
<th>Risk ratio [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial as a whole (I)</td>
<td>2518</td>
<td>645 (25.6)</td>
<td>2682</td>
<td>720 (26.8)</td>
<td>1.2</td>
<td>1.00 [0.91, 1.09]</td>
</tr>
<tr>
<td>Trial as a whole (C)</td>
<td>3156</td>
<td>576 (18.3)</td>
<td>2853</td>
<td>567 (19.9)</td>
<td>1.6</td>
<td>1.09 [0.99, 1.21]</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Site (I: intervention; C: control)</th>
<th>2012 (eligible births)</th>
<th>2012 (VBAC &amp; % of eligible births)</th>
<th>2015 (eligible births)</th>
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<th>Change in %</th>
<th>Risk ratio [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy (I)</td>
<td>736</td>
<td>61 (8.3)</td>
<td>652</td>
<td>143 (21.9)</td>
<td>13.6</td>
<td>2.43 [1.84, 3.22]</td>
</tr>
</tbody>
</table>

**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.

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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

- 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.
Information resources

Sharing our publications and presentations

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
- Lundgren et al. (2012) childbirth: A meta-analysis of women's experiences, VHA2C (Vaginal birth after Caesarean-section). A qualitative study from countries with high VHA2C rates
- Lundgren et al. (2012) Childbirth interventions to increase vaginal birth after caesarean section (VHA2C): a systematic review
- Nilsen et al. (2016) Vaginal Birth After Caesarean: Views of Women From Countries With High VHA2C Rates
- Clarke et al. (2015) Improved identification of women with a previous Caesarean section through enhanced perinatal care. (OptiBIRTH trial). Study protocol
References and recommended reading


References and recommended reading

References and recommended reading

- Mesquita, D.N., Barbieri, M.A. et al. (2013). Cesarean Section Is Associated with Increased Peripheral and Central Adiposity in Young Adulthood: Cohort Study. *PLOS ONE*, 8 (6), e66827.

References and recommended reading

Caring For You Campaign

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

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

“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)

The Law

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?

THIS IS WHAT BULLYING LOOKS LIKE

- Intimidating behaviour e.g.: ridiculing, excluding, withholding information, overloading, marginalising, micromanaging
- Threatening which can be physical or emotional
- Gossiping and spreading rumours
- Blocking professional development
- Negative and non-constructive feedback
- Sexual advances
- Criticism of skills in front of others
- Disagreement on action plans in front of patients
- Harassment
**What does being bullied feel like?**

- 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?**

- 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?

“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

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?

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

• 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**

**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**

**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.

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

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=AFQjCNfzmJaFliRIUD5bg8yhaeApQt-A

RCM- Undermining Behaviours.htm
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.
- Acknowledge what’s here - body sensations, thoughts, emotions
- Gather attention towards the breath
- Expand 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-
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!

<table>
<thead>
<tr>
<th>Stress Response</th>
<th>Stress Response Turned Inward</th>
<th>Self Compassion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fight</td>
<td>Self-criticism</td>
<td>Self-Kindness</td>
</tr>
<tr>
<td>Flight</td>
<td>Self-Isolation</td>
<td>Common Humanity</td>
</tr>
<tr>
<td>Freeze</td>
<td>Self-Absorption</td>
<td>Mindfulness</td>
</tr>
</tbody>
</table>

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
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** of 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.

**MINDFULNESS BASED STRESS REDUCTION (MBSR)**

- **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**: more present and available to those you are in relationship with - potential for better communication, engagement and connection in relationships, family and work.

**MBSR (CONT'D)**
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?

FORMAL PRACTICE: THE BODY SCAN

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

THE BODY SCAN ( CONT'D)
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  . . . .
AIMSI – What do we do?

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

How do we know what women want? We ask.

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
What Women Want?

- Safety
- Evidence based care
- Equity of care
- Good outcomes
- Information
- Choice
- Support
- A partner in decision making
- Individualised care not a factory based approach
How do women want to receive their care

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

- Can be more important than the outcome

Listening comes in all sorts of shapes and sizes

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
Who do we want to listen?

- 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

Challenges to listening

- Routine vs choice
- Convenience vs hassle
- Does the buck stop with me?
Challenges to active listening

- Requires time
- Requires skill
- Requires support

Challenges to hearing - Personal prejudice

- 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
When we need to be heard

- **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

**LANGUAGE**

**Use**
- OFFER
- INFORMED OPPORTUNITY
- PARTNERSHIP & TRUST

**Instead of**
- GIVE
- ROUTINE POLICY
- CONTROL and COERCION
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 to 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 syntocinon – medical personnel decide

Maternal position during labour and birth...

INFORMED CONSENT:

INFORMED REFUSAL
Categories of Lack of consent

**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
  - “It’s 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

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**Practice Standard 1:**
Midwifery practice is underpinned by a philosophy that protects and promotes the safety and autonomy of the woman and respects her experiences, choices, priorities, beliefs and values.
**Consent**

**WHAT MATTERS TO YOU 2014 AIMS\$I SURVEY n=2832**

- **67.7%** of women said that during labour and birth, consent was fully sought for all tests, procedures, treatments.
- **52.8%** of women said that they were fully informed of benefits, risks, and potential outcomes of tests, procedures, and treatments during labour and birth.
- **50.2%** of women were given the opportunity to make an informed refusal of a test, procedure, or treatment.
The biggest communication problem is we do not listen to understand. We listen to reply.

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 you are 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)”

Practice Standard 4:
Midwives work in equal partnership with the woman and her family and establish a relationship of trust and confidentiality.
What happens when we are not listened to?

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

Rating of services 2015

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)
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)
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!
We don’t learn from talking; we learn from listening.

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

‘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
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

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


Lancet Series on Midwifery: authors

- Endang Achadi
- Chiara Ancona
- Linda A Bartlett
- Maria Helena Bastos*
- Jim Campbell*
- Amos Channon
- Fen Cheung
- Anthony Costello
- Marcos AB Dias
- Luc de Bernis*
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- Sachiyo Yoshida

* Lead authors and Executive Group

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

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

‘Skilled, knowledgeable and compassionate care for childbirthing 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 WITH COMPLICATIONS
Framework for quality maternal and newborn care
Lancet Series on Midwifery

Practice categories
Education Information Health promotion
Assessment Screening Care planning
Promotion of normal processes; prevention of complications

FOR ALL CHILDBEARING WOMEN AND INFANTS
FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

First line management of complications
### Framework for quality maternal and newborn care

**Lancet Series on Midwifery**

**Practice categories**
- Education
- Information
- Health promotion
- Assessment
- Screening
- Care planning
- Promotion of normal processes; prevention of complications
- First-line management of complications
- Medical obstetric neonatal services

**Organization of care**
- 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

FOR ALL CHILDBEARING WOMEN AND INFANTS

Practice categories
- Education
- Information
- Health promotion
- Assessment
- Screening
- Care planning

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

Values
- Respect, communication, community knowledge and understanding
- Care tailored to women’s circumstances and needs

FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

Medical obstetric services

FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

First line management of complications

FOR ALL CHILDBEARING WOMEN AND INFANTS

Medical obstetric services

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Medical obstetric services

FOR CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS

Optimising biological, psychological, social and cultural processes, strengthening woman’s capabilities

Expectant management, using interventions only when indicated
FOR ALL CHILDBEARING WOMEN AND INFANTS

<table>
<thead>
<tr>
<th>Practice categories</th>
<th>Organisation of care</th>
<th>Values</th>
<th>Philosophy</th>
<th>Care providers</th>
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<tr>
<td>Education</td>
<td>Available, accessible, acceptable, good quality services—adequate resources, competent workforce</td>
<td>Respect, communication, community knowledge and understanding</td>
<td>Optimising biological, psychological, social and cultural processes; strengthening women’s capabilities</td>
<td>Practitioners who combine clinical knowledge and skills with interpersonal and cultural competence</td>
</tr>
<tr>
<td>Information</td>
<td>Continuity, services integrated across community and facilities</td>
<td>Care tailored to women’s circumstances and needs</td>
<td>Expectant management, using interventions only when indicated</td>
<td>Division of roles and responsibilities based on need, competencies and resources</td>
</tr>
<tr>
<td>Health promotion</td>
<td>Credibility, credibility, credibility, credibility, credibility</td>
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<td>Screening</td>
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<td>Care planning</td>
<td>Information</td>
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First-line management of complications
Medical obstetric services

Available, accessible, acceptable, good quality services—adequate resources, competent workforce
Continuity, services integrated across community and facilities
Respect, communication, community knowledge and understanding
Care tailored to women’s circumstances and needs
Optimising biological, psychological, social and cultural processes; strengthening women’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 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
Transforming midwifery education

Evidence into action

Advocacy

Research priorities

Collaboration

Tackling barriers

Quality of care

Political will

Education

Partnership working

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

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