



# BAPM News

Issue No 9

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## From the President

The guidance on Caesarean Section by the National Collaborating Centre for Women's and Children's Health, which was commissioned by NICE is a masterful piece of work in terms of information and presentation. All professionals responsible for the care of newborn babies should read it as there is helpful information on Caesarean section in relation to mother to child transmission of infection, neonatal encephalopathy and cerebral palsy, birth injury, thermal care, maternal contact and breast feeding.

This is an important publication because of its broader implications for medicine. It challenges a number of well-established practices, emphasises the importance of evidence based medicine, examines cost implications, sets standards for future audit, highlights those areas where more research is needed, and above all seeks to engage patients so that they can make choices. There is a fairly detailed explanatory section on the implications of the guidance for pregnant women, families and the public. It will be interesting to see how this comprehensive approach unfolds in other branches of medicine too, and whether it will lead to safe, efficient, and cost-effective services with harmonisation of professional accountability and patient choice.

Unfortunately most sections of the media lost the opportunity to develop this broader theme and instead couldn't resist "too posh to push", focussing on the 7% of all Caesarean sections apparently done without medical indication.

BAPM is receiving encouraging reports on the formation of neonatal networks although the pace of development is patchy. As the networks develop there will be new and better opportunities for our organisation to influence perinatal care. For example, well-structured regional meetings of network leads feeding into BAPM would, in time, be a strong basis for developing a range of cross-regional initiatives including research trials, benchmarking, and economic evaluations.

Continuing the theme in earlier paragraphs we need to ensure that

patients have a voice in neonatal networks - not because it's fashionable, but because patients are an important source of information about whether our services are meeting standards that, hitherto, may not have been foremost in our minds. Often the notion of "patient involvement" translates to the token patient on a committee whereas we need something more robust than that. We have as an ex officio member of our Executive Committee Rob Williams, Chief Executive of BLISS and together we will be exploring ways of engaging patients for the benefit of the service.

I do hope you will be able to come to the AGM and scientific meeting in Manchester in September 2004. I can assure you that the AGM will grip you with excitement and it really is an opportunity for you to shape the future of BAPM. Our Founders Lecture this year will be presented by Professor David Edwards. The four invited lectures at the scientific meeting have been selected to have broad appeal to all those working in perinatology. In addition there is room on the programme for nine shorter presentations and it is not too late to submit abstracts.

Finally, elsewhere in this news letter you will see that nominations are invited for President -Elect to take up the post at the end of the AGM in September 2004, pending my retirement as President in 2005.



### Perinatal Trainees Meeting 10 November 2004

RIBA, 66 Portland Place, London W1

0930-1000	Registration and Coffee
1000-1045	Clinical Governance: Risk management issues for each viewpoint and how it affects planning for the department eg. communication etc.
1045-1130	Enquiries into Maternal Deaths - the implications for practice
1130-1215	Late identification of fetal malformation: The advantages of joint counselling
1215-1345	Lunch ("surgeries" available for those seeking one to one advice)
1345-1415	What's on the horizon for Obstetrics?
1415-1445	What's on the horizon for neonatology?
1445-1515	Coffee
1515-1630	Debate: This house believes that neither obstetrician nor paediatricians should intervene before 25 weeks?
1630	Close

## Specialist Midwifery Service in Manchester

The Specialist Midwifery Service is based in the Zion Community Resource Centre in Hulme, Manchester. In response to the success of her previous role as (DLM) Drug Liaison Midwife (1995-2001) Faye Macrory was appointed as a Consultant Midwife in April 2001. The post was proposed and funded in the first instance by the Health Action Zone of Manchester, Salford and Trafford (HAZ) and is now supported by Central Manchester & Manchester Children's University Hospitals NHS Trust (CMMC).

Her team consists of three specialist midwives and a personal assistant. The service has a city-wide remit and broad ranging responsibilities that include providing input to three maternity hospitals, four drug service bases, a sexual health project for sex workers and the regional in-patient detox unit. It also supports and co-ordinates the care for HIV positive women identified through the antenatal HIV screening programme. The service also provides training in domestic

violence, brief interventions in alcohol and HIV testing. Women and staff in a nearby HMP Prison are also offered support. Funding has recently been identified for a specialist health visitor and another specialist midwife (mental health & domestic violence) to join the team.

Prior to 1997, all babies known to have drug-using mothers in Manchester were routinely admitted to the Neonatal Medical Unit and the majority treated by medication. Since then, babies are cared for by their mothers on the ward, usually discharged after 72 hours, breast-feeding encouraged and parenting skills promoted. While debate continues in the UK as to which drug of choice is preferred to treat neonatal withdrawal, in Manchester our innovative approach has resulted in a dramatic reduction of any pharmacological intervention at all. In the first 4 years of the DLM being in post a 65% reduction in pharmacological intervention was achieved and breast-feeding rates were increased.

Service provision is firmly rooted in the sphere of public health and embraces all aspects of a vulnerable, socially excluded life-style. This involves collaboration across a wide range of health and social agencies, both statutory and voluntary, in addressing the complex issues associated with mental health, domestic violence, sexual abuse and prostitution.

Changes in drug treatment, maternity and paediatric services are an investment in the health of future, as well as present generations. Meaningful and effective interventions have the great potential to positively impact on parenting in the long-term, reduce the need for children to be placed in care, and help to break the present cyclical nature of drug use, poverty and despair. With well-established links to many related agencies, the Specialist Midwifery Service is ideally placed to make a real difference to the lives of those they try to reach.

*Faye Macrory MBE,  
Zion Community Resource Centre*

## The Neonatal Clinical Audit Programme

The Neonatal Clinical Audit Programme is an exciting new project funded by the Healthcare Commission and supported by the Department of Health and the Royal College of Paediatrics and Child Health. Its inception follows the DH Neonatal Review in 2003. The aim is to develop a national, web based, neonatal database to be used for auditing and improving clinical care standards in England and Wales.

The project was first announced publicly at the RCPCH spring meeting in York on 30 March 2004. This was a well-attended, lively meeting, with delegates invited from all Health Authorities and also relevant user groups.

Since that meeting, a programme board with broad multi-professional representation has been established to oversee the project. The Healthcare Commission are particularly concerned with improving user experience so, as well as clinical standards, the audit will include standards relating to the experiences of the families of babies treated in the units.

The first phase of the project, which began in February 2004, is a scoping

exercise to establish the current situation in relation to neonatal intensive care audit; a questionnaire was sent to all 200 neonatal units and the results are now being analysed to establish current data collection practices. If you have received a questionnaire and have not yet returned it **please do so as soon as possible!**

At the end of June 2004, a report will be presented to the programme board detailing the current situation and providing an outline plan for rest of the project, which will be run from the Research Division of the RCPCH.

The second phase of the project, which will begin in July 2004, will see the formation of an Implementation Board and Clinical Advisory Board to look at the wider issues of this project in greater detail. A number of working groups will be set up, reporting to the Implementation Board, to undertake specific tasks such as agreeing a minimum clinical dataset to underpin evidence-based audit and addressing IT, consent/confidentiality

issues, data feedback and consumer issues. As the Healthcare Commission believe that data reporting should be open and honest, it is anticipated that reports generated from the audit will be accessible eventually to the general public as well as providing detailed feedback to contributing units who will be able to access data for their own local audit purposes.

In the third phase, starting around June 2005, pilot neonatal intensive care units will be invited to begin contributing data so that the first audit outputs will be available in the twelve months after this date. It is anticipated that this will be a continuing national audit, with funding

available for the foreseeable future and that the audit will eventually roll out to all units providing care for the newborn.

Further information on the project can be found at [www.ncap.org.uk](http://www.ncap.org.uk)

*Marie Hubbard  
Neonatal Audit Project Manager*



Neonatal Clinical Audit Programme

## Letter from the Honorary Secretary

This is certainly a time of great activity and change affecting perinatal services. The formation of networks is going ahead in England at what appears to be a rather variable rate and similar plans seem to be evolving in Wales and Scotland. Across the country, new transport services are emerging using a variety of organisational models. However, at least two new influences will come in to play in the next few months: the European Working Time Directive and the Children's and Maternity NSF. At the present time it is impossible to assess the impact of these two major drivers for change on perinatal care. In addition to all this some on going issues remain unresolved. The regulations surrounding ANNP prescribing are to be changed in new legislation and many of you will have seen the current draft (flagged to all members with registered e-mail addresses) suggesting that ANNPs will be able to prescribe "unlicensed" (for neonates) medication but that all their prescribing should follow diagnosis by a doctor. Clearly such a change would have a limited impact on the current problems that exist in relation to this matter.

It is clearly difficult for all of us to keep abreast of these different changes and how they are progressing. However, I think it is important for all members to have an opportunity to see what is happening around the UK both in relation to neonatal networks and perinatal services in general as many of these issues have important local implications. We will continue to share information we get about any of the above via e-mail and the website. In relation to networks in particular we have gone some way to filling in the information on the BAPM website about network boundaries and providing key contact information. **Please provide news about your local network and its activities and changes in patterns of service delivery as they emerge.** I know our colleagues at BLISS are equally interested in this information and are planning to contact each network (with the support of DoH) to ask how the money identified for neonatal care has been spent. I hope they will allow us to add the responses to our website as and when they become available.

Whilst on this theme, it is perhaps sensible to mention the national neonatal audit project. Money dedicated for this purpose became available during the last financial year and this recurrent investment was clearly welcomed. More recently, the formation of CHAI introduced a new consideration ie key indicators of "performance", which all perinatal services will collect and which will inform CHAI's audits when they visit individual hospitals. Therefore, a study will be designed to identify a system which will meet the wishes of the various stakeholders, clinical and non-clinical. The study will have strong BAPM involvement but will be run by the RCPCH and managed by the West Midlands Specialist Commissioning Agency. I am sure further updates will follow as and when they are available.

Now that BAPM has grown we seem to be enclosing election papers for new members of the Executive with each Newsletter and this occasion is no different! However, on this occasion, one of the posts is that of President. Malcolm Chiswick still has over a year of his three-year term to go but it is at this stage that we elect his replacement in order to ensure a smooth handover. The new President-Elect will join the Executive from September 2004. Clearly this is a major role as the President normally chairs all meetings of the Executive and is often asked to represent BAPM at a variety of important meetings related to perinatal care. I am sure Malcolm would be happy to speak personally to anyone wishing to stand for the post. If we have more than one applicant we will hold an election during the early Summer in order that the process is complete by the time of the AGM. Please give careful thought to whom you would like to see in this role. We are also seeking a deputy neonatal representative for the south of England (see the map on the website for the exact constituency). The elected individual will become the full EC representative for this area after 3 years. We are also seeking a deputy obstetric representative who will become a full EC member after 1 year. (Obstetric representatives are not tied to a specific locality as our obstetric members are not spread evenly across the UK).

I hope those of you that attended enjoyed the Spring meeting in York. I was there for Monday, Tuesday and Wednesday and was once again disappointed by the fact that a number of the best perinatal papers were presented in plenary sessions away from the main perinatal days which meant few in the audience seemed to understand their significance. However I felt the main perinatal session had some interesting material and the joint session with the Allergy, Infection and Immunity group was excellent. I hope to see lots of you at the Trials group meeting on 19/5/04 - essential I think for anyone trying to get to grips with the new EU Trials regulations. The AGM and September scientific meetings I hope will be excellent, certainly a huge amount of effort has gone into all aspects of the planning including looking for the most economical venues. Remember abstracts need to be in by 4/6/04 (see website for details).

Finally although my term of office does not end until September (and I will be producing the relevant section of the Annual Report) this is my last news letter. I will have been involved with the Executive (starting as a deputy neonatal representative) for 10 years and a huge amount has changed during that time, including BAPM. I have enjoyed my various roles enormously and I hope more and more of you will seek to get involved with aspects of BAPM work. Personally I feel the role for a group that brings together all of the professionals involved in perinatal care is more important than ever. I include in this the families we all deal with and hence I see our growing relationship with BLISS as being very important to the future. To emphasise this point I am one of a group taking part in the Great North Run to raise money for BLISS. It is my intention, nearer the date, to shamelessly exploit my position as BAPM Secretary to e-mail all of you seeking sponsorship.

My thanks go to all the people I have worked with over the last few years especially Christine Cooper who joined BAPM as administrator at the time I became Secretary and good luck to Andy Lyon as he takes over in September.

Best wishes



## Neonatal Interest Group for Physiotherapists

This group was formed in October 2003 by physiotherapists specialising in working in the neonatal intensive care and special care settings. It is a sub-speciality group of the Association of Paediatric Physiotherapists (APCP).

Neonatal care is a relatively new but expanding field of practice for therapists in this country, although one that is well established and recognised in countries such as Australia and the United States of America. An advanced level of competency and clinical judgment are required which can only be achieved through specialist training, study and practice.

The first tasks of the physiotherapy neonatal group were to establish a membership database and to undertake a skill survey of members. The group now has approximately 75 members and the survey revealed that the provision of physiotherapy varies greatly across the UK, ranging from none to full-time dedicated posts. We hope to extend and develop the survey and use the information to develop a mentoring scheme across the country to share expertise. Regional groups have already been established which meet regularly and there have been several national meetings.

Outcome studies over the last decade show a dramatic increase in survival rates of infants admitted to neonatal intensive care units but also show associated significant morbidity, particularly in infants after extremely preterm birth. There is some evidence to suggest that early intervention can result in a more positive outcome for these high-risk infants. The need, therefore, to identify and evaluate those infants most at risk and to instigate early intervention has been acknowledged. Specialist neonatal physiotherapists as part of the neonatal team have skills which can assist with early identification and intervention. The therapist can provide developmentally and physiologically appropriate therapy that is sensitive to the environmental and social needs of the infant and his or her family.

This developmental framework for early intervention and developmental care is common for many disciplines with a degree of overlapping of roles, particularly between physiotherapists, occupational therapists, developmental psychologists and specialist nursing staff. There are areas, however, that are unique to physiotherapy, which include respiratory care, the assessment and analysis of movement patterns and postural dysfunction, orthopaedic issues as well as assessment and identification of gross motor dysfunction in follow-up.

Specialist training for physiotherapists has not been readily available in this country until more recently. An important

aim of the clinical interest group is to identify training needs and from this develop an educational programme. Dedicated courses, including multiprofessional courses, the encouragement of clinical peer supervision and mentoring, will provide a more structured career pathway to build up knowledge, expertise and competency to a nationally agreed standard.

The group has identified a pressing need to develop defined competencies to practice and ensure that physiotherapy intervention and assessment is based on as sound an evidence base as is currently available to us. The encouragement of further research in this field has therefore been identified as an objective for the group to address.

Main Roles of Physiotherapists in the Neonatal Intensive Care Unit include:

- screening of infant population to identify infants at-risk from neuro-developmental sequelae and to determine the need for on-going follow up within community services;
- detailed assessment of neuromotor development in infants identified at risk;
- development and implementation of care plans for infants to prevent physiological compromise, behavioural stress, and secondary musculo-skeletal complications;
- development and implementation of respiratory physiotherapy care plans for infants as needed;
- design, implementation and evaluation of intervention plans and strategies in collaboration with the family and neonatal team;
- advice to parent/care-givers on normal development, handling techniques and adaptive equipment as necessary;
- participation in parent support groups;
- development and implementation of discharge plans in collaboration with care givers and community resources;
- education - teaching, dissemination of information and training of other professionals, both in the acute and community setting; the dissemination of information to parents through dedicated in-service training programmes, informal and formal teaching sessions and demonstration.

Finally, our second conference is to be held in Edinburgh on 28th/29th October 2004. All are welcome to attend this meeting.

For more information about the group please contact Peta Smith, CHAIR of the Neonatal Interest Group (APCP) on [Peta.Smith@ekentc-tr.sthames-nhs.uk](mailto:Peta.Smith@ekentc-tr.sthames-nhs.uk)

*Sally Jary,  
Clinical Specialist Physiotherapist  
Multiprofessional Liaison Officer,  
Neonatal Interest Group (APCP)*

## Diary Dates 2004

### 7-9 July

British Congress of Obs & Gynae  
Glasgow

### 2-3 September 2003

AGM and Scientific Meeting  
University of Manchester, Hulme Hall,  
Manchester

### 10 November 2004

Perinatal Trainees Meeting  
RIBA, 66 Portland Place, London W1

## Annual Scientific Meeting 3 September 2004

### CALL FOR ABSTRACTS Deadline: 5pm on 4 June 2004

Abstracts are invited for presentation at the above meeting in Manchester. They may cover any aspect of perinatal medicine and should be submitted online ([www.bapm.org](http://www.bapm.org)) or using the form available from the website or the Administrator. For more information, see [www.bapm.org](http://www.bapm.org).

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