

## Latest NCT resources target new fathers

The National Childbirth Trust (NCT) has launched a set of resources including online booklets and a DVD to help new fathers adjust to their role.

Two free online booklets, *Becoming a parent* and *Early days with your baby*, have been written by dads, for dads. They explain the options available when making key decisions and cover topics such as understanding the different stages of pregnancy, developing a birth plan, changing lifestyles, juggling life as a parent and managing finances.



The DVD *Daddy Cool* costs £4.99 and combines reliable information from NCT experts with interviews from dads-to-be who share their real-life experiences. It follows them through the final stages of their partner's pregnancy, and covers live birth and the first weeks of their baby's life.

Booklets from [www.nct.org.uk/dads](http://www.nct.org.uk/dads), DVD from [www.nctshop.co.uk](http://www.nctshop.co.uk) or 0845 8100100

## ACT launches children's palliative care training and consultancy programme

UK children's palliative care charity ACT has launched a children's palliative care learning and consultancy programme called 'Train to Care' for all professionals who work with life-limited children.

With funding from the Department for Education, the programme has been designed to raise standards in children's palliative care by encouraging organisations to develop their team's confidence, expertise and skill set.

It draws on the shared knowledge of many of the UK's leading children's palliative care experts and has two main elements:

- Learning: modules on topics in children's palliative care to develop knowledge, skills and confidence.
- Consultancy: to help improve, evaluate or develop new services.

Visit [www.act.org.uk/traintocare](http://www.act.org.uk/traintocare), email [traintocare@act.org.uk](mailto:traintocare@act.org.uk) or call ACT on 0117 916 6422.

## New networks may help to tackle child surgery shortfall

Sick children face unnecessary delays or long distance travel for routine surgery unless co-ordinated action is taken now by the surgical profession and the NHS, warns the Royal College of Surgeons.

Guidance published by the Children's Surgical Forum calls for the establishment of new networks across NHS boundaries to provide routine surgical services for children in local hospitals. *Ensuring the provision of general paediatric surgery in the district general hospital* proposes that NHS commissioners, trusts and specialist units work together to set standards, share skills and ensure patients are treated in the most appropriate hospitals.

Su-Anna Boddy, Consultant Paediatric Urologist and Chair of the Children's Surgical Forum, said: "Sick children should not have to face long journeys or delays for relatively straightforward operations which, until recently, would

have been available at their local hospital. General operations like hernia repairs are increasingly diverted to specialist paediatric units. These units are completely snowed under and struggling to cope."

Traditionally, operations on children were carried out by the same general surgeons and urologists who treated adults, but numbers have dwindled due to retirement, while surgical training is increasingly focused on specialist paediatric surgery for rare and childhood-specific conditions. No general surgery trainees have undertaken the optional general paediatric surgery exams in past years. In addition, many NHS Trusts have failed to prioritise paediatric surgical services. Newly advertised consultant positions for general surgeons or urologists do not encourage applicants with an interest in children's surgery.

View the guidance at: [www.rcseng.ac.uk](http://www.rcseng.ac.uk)



## Childbirth DVD helps to inform parents-to-be

A DVD about childbirth filmed on location at Colchester General Hospital is now available. *Childbirth & You – Understanding Interventional Childbirth* has been developed from an idea by Mr Barry Whitlow, Consultant in Obstetrics and Gynaecology at the hospital (pictured).

He was concerned by a lack of information about interventional births, compared with natural births. He approached Health Enterprise East (HEE), the NHS Innovations Hub for the eastern region, which supports NHS staff who come up with ideas to benefit patients.

"What causes anxiety for women and their partners is when obstetricians have to intervene in a birth," he said. "Yet this is an area where there is a need for more factual information, whereas there is plenty of material readily available about more straightforward deliveries."

The 45-minute DVD covers a variety of topics, including caesarean section, forceps and ventouse deliveries and pain relief, as well as natural birth.

*Childbirth & You* is available from many DVD outlets, including Amazon and Play.com, RRP £9.99

## Helping parents make critical care decisions

The *Making critical care decisions for your baby* leaflet, produced by Bliss, has been sent to all neonatal units around the UK and reflects the General Medical Council's new end-of-life care guidance. It aims to help parents when deciding whether to continue or stop the intensive care of their baby.

The leaflet is endorsed by the Neonatal Nurses Association and the British Association of Perinatal Medicine.

The leaflet covers what families might expect when faced with the prospect of their baby dying and how staff will work with them as part of a team to make a well-informed choice in the best interest of their baby. It offers information on other people who can give help, support and advice.

The leaflet has a tear-off cover sheet which health-



Public Health Minister Anne Milton visited St Thomas' Hospital's maternity unit and the Evelina Children's Hospital's neonatal unit in June to mark Sands Awareness Month. The hour-long visit provided the minister with an overview of the maternity unit, the neonatal unit and the Sands suite, available to parents whose baby is stillborn or dies shortly after birth. During her time at the hospital, Anne Milton also met with staff and families and is pictured with Dervla Goldie and her son Angus.



care professionals can fill in, to document the conversation and add to the baby's medical notes.

Andy Cole, Bliss Chief Executive and co-author of the leaflet, said: "We hope that health professionals will use this resource to help them at what is a very difficult and emotional time for everyone. Making these complex decisions is never easy and we

hope that this publication will offer a little extra help."

Dr Jag Ahluwalia, Medical Director, Cambridge University Hospitals NHS FT who consulted on the leaflet, said: "Parents of very sick babies will often face having to make difficult decisions along with their babies' clinical carers."

Copies are available from [farrahp@bliss.org.uk](mailto:farrahp@bliss.org.uk) or 0207 378 1122

## Comment from stillbirth and neonatal death charity Sands...

### Disparity in care for bereaved parents

A survey conducted by Sands, the first of its kind in the UK, investigates the standards of bereavement care provided by UK maternity units to parents whose baby dies before, during or shortly after birth.

In most units the provision of care for bereaved parents has improved over the last few decades, however, in around 20% of units that responded, care is still poorly resourced and organised.

The survey revealed disparities in the care provided to parents, for example:

- 52% of maternity units have no dedicated bereavement support midwife
- 45% of units have no dedicated room on the labour ward for mothers whose

baby has died, where they cannot hear other mothers and babies.

- In a small number of units, women having a miscarriage are cared for in areas that are clearly unsuitable, for example on a medical or general ward or in an A&E department.
- 82% of units have no information in formats suitable for parents with visual impairments
- 86% of units have no information in formats suitable for parents with learning disabilities.

Few of the changes identified in the report can be made by staff delivering the care. Almost all must be initiated by managers or by service commissioners.

### Babies born outside normal working hours at higher risk

A Scottish study published on *bmj.com* concludes that babies are at a higher risk of dying soon after delivery if they are born outside normal working hours.

Commenting on the report Janet Scott, Sands Research Manager, said: "It is shocking that some babies are dying directly because the quality of care at night and weekends is poorer than care during working hours.

"A baby's life should not rest on whether or not they are born in office hours."

"We have known for well over a decade that sub-optimal care leads to avoidable deaths. This study adds to evidence that babies' lives are put at risk when access to experienced staff and facilities is limited."

Possibly a quarter of the term neonatal deaths due to anoxia in labour (a sensitive measure of care in labour and delivery) were due to the increased risk of delivering at night and weekends. Furthermore the study suggests there may be a similar increase in the risk of stillbirth in labour.

### Perinatal mortality report

The CMACE Perinatal Mortality Report 2008 reports a decrease in perinatal mortality for 2008. However, Sands warns that there is no room for complacency about stillbirths and neonatal deaths in the UK.

Sands Research Manager Janet Scott comments: "The reported fall in stillbirth rates is too small to give much cause for optimism. The neonatal mortality rates continue to fall, which is welcome, but much more can be done to bring the rates down further. Meanwhile the actual numbers of babies dying each year are as high as ever due to the UK's rising birth rate, with 4,000 babies stillborn every year, and a further 2,500 babies dying shortly after birth."

The number of babies that start labour apparently healthy and then die remains stubbornly consistent with around 500 babies dying each year, some of which stem from untoward incidences during delivery. Sands supports CMACE's call for each of these deaths to be fully investigated and lessons learned to prevent avoidable tragedies in the future.

To see the CMACE report visit: [www.cmace.org.uk](http://www.cmace.org.uk)