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<tr>
<th>Name:</th>
<th>Boubou Hallberg</th>
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<tbody>
<tr>
<td>Job Title:</td>
<td>Head of Neonatal department, Karolinska University Hospital</td>
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<tr>
<td>Title of talk:</td>
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<td>Biographical Sketch:</td>
<td>Boubou Hallberg is the head of the Neonatal department at Karolinska University Hospital in Stockholm. He received his Ph. D. in 2010 with a dissertation on Hypoxic Ischemic Encelopathy (HIE) and Hypothermia treatment. Boubou has a special interest in leadership, medical research, healthcare development and education. He works actively with change management and implementation, with focus in areas such as value-based healthcare, new intervention treatment and tertiary care. Boubou Hallberg had published 30 scientific articles in international journals, and he is currently active in several international organisations as an expert and leader.</td>
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<td>Lecture Abstract:</td>
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</table>
**Name:** Dr Christopher Lockhart  

**Job Title:** Consultant Cardiologist-Adult Congenital Heart disease  

**Title of talk:** Long-term outcomes following palliative surgery for congenital heart disease

| **Biographical Sketch:** | Dr Lockhart is a Consultant Cardiologist and network lead for Adult Congenital Heart Disease working at the Royal Victoria Hospital within the Belfast Trust.  
After graduating with honours from Queens University Belfast in 2002, he gained membership of the Royal College of Physicians in 2005, and subsequently entered the specialty training programme for adult cardiology in Northern Ireland. Through 2010-2011 he worked in the adult congenital heart disease department in the Royal Brompton Hospital in London, and completed his training in 2012 at the Royal Victoria Hospital focusing on paediatric cardiology.  
Dr Lockhart took up post in Belfast as a consultant ACHD cardiologist in August 2012 and since then, in addition to overseeing the clinical care of ACHD patients in Belfast, has been responsible for setting up a regional ACHD service for Northern Ireland with network links to other major centres, and a formal transition service from paediatric cardiology. He oversees a formal ACHD research programme.  
His clinical interests cover all aspects of ACHD care including inpatient and outpatient care, pulmonary hypertension associated with congenital heart disease, heart disease and pregnancy, cardiac catheterisation in ACHD patients and also trans-oesophageal echocardiography, in particular during interventional ACHD procedures. |

| **Lecture Abstract:** | With advances in paediatric cardiology and in particular paediatric cardiac surgery, more children are surviving, often well into adulthood. There are now more adults living with congenital heart disease in the UK than children; often requiring at least one further surgery in their teenage/adult year.  
This lecture will discuss the long term physical and psychological outcomes in those with cardiac defects repaired in infancy and childhood, specifically with reference to the population in Ireland. |
Name: Ronny Knol
Job Title: Neonatologist
Title of talk: Physiology of newborn transition with an intact umbilical cord

Biographical Sketch:
Dr. Ronny Knol is from the Netherlands and he obtained his Medical Degree at the Radboud University Medical Centre in Nijmegen. Pediatric training was completed at the University Medical Centre Utrecht in 2009. Subsequently his specialized Neonatal training started, including one year at the University Hospital Gasthuisberg in Leuven (Belgium). He is a consultant neonatologist at the Department of Neonatology of the Sophia Children’s Hospital – Erasmus Medical Centre in Rotterdam since 2011. He developed a special interest in newborn transition and is collaborating with Dr. Arjente Pas (Leiden University Medical Centre) on this subject. Together they coordinate the Aeration, Breathing and then Clamping project.

Lecture Abstract:
Preterm infants are most vulnerable immediately after birth and the management in the first minutes of life can have a major impact on important morbidities associated with prematurity (1). During the transition to life after birth, lung aeration is pivotal for the physiological changes in respiratory and cardiovascular function that are required for survival after birth (2). However, most preterm infants fail to aerate their immature lungs and cord clamping is then required to transfer apnoeic preterm infants to a resuscitation table to provide respiratory support.

Studies in preterm infants have shown that delayed cord clamping (DCC) reduces the risk of important preterm morbidities (3). Moreover, experimental studies demonstrated that DCC until after ventilation onset sustains preload and cardiac output and avoids the large disturbances in systemic and cerebral hemodynamics during transition (4). Preterm infants could potentially benefit from this approach. Ongoing (pre-)clinical research in preterm transition is focusing on initiating respiratory support with an intact umbilical cord, still mostly using a time-based cord clamping approach (5, 6). Using a respiratory function monitor during transition will be helpful to assess adequate spontaneous breathing. This Aeration, Breathing and then Clamping (ABC) approach might optimize cardiorespiratory transition and result in a more physiology-based cord clamping.

References:
# Lecture Abstract:

The survival chances of preterm infants have improved considerably in the last few decades. The advantages of giving breast milk to neonates and infants for a sufficiently long period, using this as the sole feeding method as far as possible, have been sufficiently demonstrated.

At least for preterm infants, breast milk is additionally an urgent medical and thus simultaneously a therapeutic intervention: it significantly reduces the typical morbidity of these children, increases the survival rate and improves long-term outcomes.

This presentation aims to give a short overview about the benefits of human milk feeding specially for the tiniest infants to give them the best chances for their long-term development. Also, it will describe that feeding breast milk is a cost-effective way by reducing severe complications like NEC, ROP or BPD.

# References:

**Book:**
“Use of Breast Milk for Feeding Preterm Infants”
UNI-MED SCIENCE
ISBN 978-3-8374-1539-1
www.uni-med.eu
**REaSoN 2017**

**Speaker Abstract Pro-forma**

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<tr>
<th>Name:</th>
<th>Michele Upton</th>
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<tr>
<td>Job Title:</td>
<td>Patient safety Policy Lead, Maternity and Newborns, NHS Improvement</td>
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<td>Title of talk:</td>
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**Biographical Sketch:**

Michele works as Patient Safety Policy Lead for Maternity and Newborn, NHS Improvement. She trained as a registered nurse and midwife in South Africa, before relocating to the UK in 1993. She undertook her neonatal nurse training in Cambridge where she worked as a clinician, clinical risk manager and lead nurse for the Neonatal ICU. In 2010 she was seconded to the East of England Perinatal Network as Innovation lead, where she implemented a number of network wide quality improvement projects aimed at improving patient safety, reducing variation in practices across the network and improving outcomes through the provision of standardised models of care. Michele’s role in NHS Improvement involves advising on policy matters as well as providing clinical insight and response to safety issues for women and newborns. This provides for a rich, exciting and varied work load with involvement in a number of initiatives across the wider healthcare system. Michele is also a qualified Neonatal Life Support trainer and Nursing Editor for Infant journal.

Michele.upton@nhs.net

**Lecture Abstract:**

Never before has there been an environment so focused on improvements in safety and outcomes for mothers and babies. This talk will outline the current political and national focus on perinatal safety – highlighting opportunities for neonatal teams to work in collaboration with maternity teams at all levels of the system to deliver lasting improvements in care and outcomes. Programmes covered in this talk include Atain, the Maternal and Neonatal Health Safety Collaborative and will touch on how other organisations safety and improvement work have been brought together to ensure seamless, joined up delivery for front line teams.

**References:**

https://improvement.nhs.uk/resources/preventing-avoidable-admissions-full-term-babies/


https://www.google.co.uk/search?q=maternity+safety+action+plan&oq=maternity+safety+&aqs=chrome.1.69i57j69i59j0j4&sourceid=chrome&ie=UTF-8

https://www.england.nhs.uk/mat-transformation/
# REaSoN 2017

## Speaker Abstract Pro-forma

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<thead>
<tr>
<th>Name:</th>
<th>Calum Roberts</th>
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<tr>
<td>Job Title:</td>
<td>Consultant Neonatologist, Monash Children’s Hospital, Melbourne, Australia</td>
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<tr>
<td>Title of talk:</td>
<td>The HIPSTER Trial: High Flow as Primary Respiratory Support for Preterm Infants</td>
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<tr>
<td>Biographical Sketch:</td>
<td>Calum Roberts is a neonatologist from Scotland, who completed his training in the UK and in Melbourne, Australia. He has held consultant posts in Middlesbrough, and for the Victorian neonatal retrieval service, before taking his current position at Monash Children’s Hospital. Calum’s PhD study, completed at The Royal Women’s Hospital in Melbourne, was based on the use of nasal High Flow treatment in preterm infants. In addition to his clinical post, he holds a research appointment with Monash University, with a focus on neonatal resuscitation and respiratory support.</td>
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<td>Lecture Abstract:</td>
<td>The HIPSTER Trial, an international multi-centre non-inferiority study, conducted in Australia and Norway, is the largest published randomised trial of High Flow in neonates. Preterm infants of 28 weeks’ gestation and above, who had not been intubated or received surfactant treatment, were randomised to either High Flow or CPAP as primary treatment for early respiratory distress. The primary outcome of the trial was treatment failure, defined by pre-specified oxygenation, blood gas and apnoea criteria, or need for urgent intubation. This lecture will cover the results of the trial, including the primary outcome and other important outcomes, and will discuss how these findings can be interpreted into practice.</td>
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<td><strong>Name:</strong></td>
<td>Professor Lucy Chappell</td>
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<td><strong>Job Title:</strong></td>
<td>NIHR Research Professor in Obstetrics</td>
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<tr>
<td><strong>Title of talk:</strong></td>
<td>Stratifying risk in pregnancy - Does it make a difference?</td>
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### Biographical Sketch:
Professor Lucy Chappell is NIHR Research Professor in Obstetrics at King’s College London and Honorary Consultant Obstetrician at Guy’s and St Thomas’ NHS Foundation Trust. She runs a research programme investigating prediction and prevention of adverse pregnancy outcomes, particularly in women with pre-existing co-morbidities such as chronic hypertension and chronic kidney disease, using randomised controlled trials and observational studies. She has subspecialty training in maternal-fetal medicine and a Masters in higher education, supervising higher degree students from obstetric, nephrology and general practice backgrounds. She is an academic editor for PLoS Medicine journal, a member of the NIHR HTA Clinical Evaluation and Trials board, and a committee member for the Blair Bell Research Society, RCOG Maternal Medicine Clinical Studies Group, and the International Society for the Study of Hypertension in Pregnancy council.

### Lecture Abstract:
Stratification of risk in pregnancy is an appealing concept for women, obstetricians and neonatologists but is harder than first appearance suggests. Recent research has focused on risk stratification for pre-eclampsia and preterm birth but challenges include appropriate validation and subsequent utilisation. The search for high-performing predictive and prognostic tests in pregnancy and the implications of such tools will be explored.

### References:
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<tr>
<th>Name:</th>
<th>Dr Elaine Boyle</th>
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<tr>
<td>Job Title:</td>
<td>Associate Professor in Neonatal Medicine</td>
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<tr>
<td>Title of talk:</td>
<td>Proposer - “This house believes that sedation must always be used for intubation....”</td>
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</table>

**Biographical Sketch:**

Elaine Boyle is an Associate Professor in Neonatal Medicine at the University of Leicester, and Honorary Consultant Neonatologist at the University Hospitals of Leicester NHS Trust. She initially trained as a nurse and worked in nursing for a number of years before changing direction to study medicine at the University of Sheffield, qualifying as a doctor in 1993. Elaine completed postgraduate training in paediatrics in Sheffield and Birmingham. Before taking up her current appointment in Leicester in 2006, she trained in academic neonatal medicine in Edinburgh, Scotland and at McMaster University, Canada. During this time she gained an MD for work on the assessment and management of pain in the newborn, an MSc in Epidemiology, and a PhD focused on enteral feeding in preterm neonates. Her current major research interest is the effects of gestational age at birth on neonatal and childhood outcomes, and in particular the effects of moderate-late preterm birth. She was the lead for the LAMBS - Late And Moderately preterm Birth Study, one of the first large population-based studies in this area. However, she remains active in research in neonatal pain, most recently as a co-investigator and UK National Principal Investigator for the EU-funded Europain Survey of management of pain in preterm and sick neonates across Europe.

**Lecture Abstract:**
## REaSoN 2017
### Speaker Abstract Pro-forma

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<tr>
<th>Name:</th>
<th>Neil Patel</th>
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<tr>
<td>Job Title:</td>
<td>Consultant Neonatologist, Royal Hospital for Children, Glasgow.</td>
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<tr>
<td>Title of talk:</td>
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<td><strong>Biographical Sketch:</strong></td>
<td>Neil is a neonatologist at the Royal Hospital for Children, Glasgow. He leads the Helping Us Grow Group (HUGG), a unique collaboration of families and staff developing and implementing family integrated care in the neonatal unit. Neil is a Scottish Quality and Safety Fellow and a Senior NHS Research Scotland (NRS) Fellow. His interests include quality improvement, staff and family empowerment, neonatal haemodynamics and non-invasive monitoring.</td>
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<td><strong>Lecture Abstract:</strong></td>
<td>There is growing evidence that involving families as caregivers in the neonatal unit (Family Integrated Care, FIC) can lead to improved outcomes for infants, their families and service providers. However, implementing FIC can be challenging, requiring change to embedded practice, models of care, and staff roles. The Helping Us Grow Group (HUGG) is a unique collaboration of families and staff in the Neonatal Unit at the Royal Hospital for Children, Glasgow. In this presentation we hope to share our experience of developing and instituting our model of FIC over the past 18 months. Empowerment and engagement of families and staff combined with inspiring innovation are central to our work. We will describe the processes and challenges of developing FIC in our busy, large neonatal unit as well as the positive transformations in culture, relationships and care that we have all experienced. Please find us @HUGGrhc</td>
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| References:        |                                                 |
**Name:** Anna Lavizzari, MD  
**Job Title:** Attending Physician, Neonatal Intensive Care Unit, Department of Clinical Sciences and Community Health, University of Milan Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico – Milan, Italy  
**Title of talk:** High Flow Therapy as primary treatment for respiratory distress of preterm infants: the Italian experience.

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<th>Biographical Sketch:</th>
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<tr>
<td>I earned my medical degree in General Medicine and Surgery in 2006 from the University of Florence. I am board certified in Paediatrics since 2012 (University of Milan). I completed my training in Pediatrics and Neonatology at the Neonatal Intensive Care Unit, Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico - University of Milan, directed by Professor Fabio Mosca. During my training, I developed a strong interest in neonatal respiratory physiology, neonatal respiratory support and neonatal resuscitation. I did a research fellowship at the Murdoch Children’s Research Institute in Melbourne in 2013-2014, investigating different strategies for neonatal resuscitation in preterm lambs and less invasive methods of delivering surfactant, under the supervision of Dr David Tingay and Prof Peter Dargaville. I have and continue to participate in experimental research on the long-term complications of preterm birth and prolonged mechanical ventilation in former preterm lambs under the guidance of both Dr. Jane Pillow in Perth (University of Western Australia) and Dr. Kurt Albertine in Salt Lake City (University of Utah). I have been working as an attending physician in the Neonatal Intensive Care Unit at Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico - University of Milan since December 2014. My clinical research projects have been focused up to now on neonatal non-invasive respiratory support, Forced Oscillation Technique for assessing respiratory mechanics, Sustained Lung Inflation, and minimally invasive surfactant administration. I have been a member of the Pulmonology Board of the Italian Neonatal Society and a young member of the Pulmonology section of the ESPR.</td>
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**Lecture Abstract:**

Heated, humidified high-flow nasal cannula (HHHFNC) has gained increasing popularity as respiratory support for newborn infants in recent years. We conducted an unblinded, monocentric, randomized clinical noninferiority trial at our tertiary neonatal intensive care unit aiming to determine whether HHHFNC provides respiratory support noninferior to nasal continuous positive airway pressure (nCPAP) or bilevel nCPAP (BiPAP) as a primary approach to RDS in infants older than 28 weeks’ gestational age (GA).

Inborn infants at 29 weeks 0 days to 36 weeks 6 days of GA were eligible if presenting with mild to moderate RDS requiring non-invasive respiratory support. Criteria for starting non-invasive respiratory support were a Silverman score of 5 or higher or a fraction of inspired oxygen higher than 0.3 for a target saturation of peripheral oxygen of 88% to 93%. Infants were ineligible if they had major congenital anomalies or severe RDS requiring early intubation. Intervention: they were randomized to either HHHFNC at 4 to 6 L/min or nCPAP/BiPAP at 4 to 6 cmH2O. The primary outcome was the need for mechanical ventilation within 72 hours from the beginning of respiratory support. The absolute risk difference in the primary outcome and its 95% confidence interval were calculated to determine noninferiority (noninferiority margin, 10%). An intention-to-treat analysis was performed.

A total of 316 infants were enrolled in the study: 158 in the HHHFNC group (mean [SD] GA, 33.1 [1.9] weeks; 52.5% female) and 158 in the nCPAP/BiPAP group (mean [SD] GA, 33.0 [2.1] weeks; 47.5% female). The use of HHHFNC was noninferior to nCPAP with regard to the primary outcome: failure occurred in 10.8% vs 9.5% of infants, respectively (95% CI of risk difference, −6.0% to 8.6% [within the noninferiority margin]; P = .71). Significant between-group differences in secondary outcomes were not found between the HHHFNC and nCPAP/BiPAP groups, including duration of respiratory support (median [interquartile range], 4.0 [2.0 to 6.0] vs 4.0 [2.0 to 7.0] days; 95% CI of difference in medians, −1.0 to 0.5; P = .45), need for surfactant (44.3% vs 46.2%; 95% CI of risk difference, −9.8 to 13.5; P = .73), air leaks (1.9% vs 2.5%; 95% CI of risk difference, −3.3 to 4.5; P = .70), and bronchopulmonary dysplasia (4.4% vs 5.1%; 95% CI of risk difference, −3.9 to 7.2; P = .79). In this study, HHHFNC showed efficacy and safety similar to those of nCPAP/BiPAP when applied as a primary approach to mild to moderate RDS in preterm infants older than 28 weeks’ GA.

**References:**


**Biographical Sketch:**
Dr Helen Chitty is a neonatal trainee who has done most of her training in the North East of England. Helen’s passion for clinical research started whilst working with the neonatal team at The James Cook University Hospital in Middlesbrough, UK. She then developed this further at The Royal Women’s Hospital in Melbourne in 2011. There, through a project on hypothermia in preterm infants, she became interested in the evaluation and optimisation of standard interventions in neonatal care.
After returning from Melbourne Helen took up a post as Neonatal Research Fellow at The James Cook University Hospital. She was Principal Investigator for The VoluVent Trial, the first randomised controlled trial to compare two types of volume-targeted ventilation in newborn infants. Under the supervision of Professor Sinha and Professor Tin she led all aspects of this comparative effectiveness trial which forms part of her Doctorate of Medicine postgraduate degree (Newcastle University). Her thesis focuses on research into complex interventions within the neonatal intensive care setting. The major themes include ventilation and methods of consent for research in an emergency context. This work has instilled in Helen a desire to improve neonatal care by enhancing the design of clinical trials. By ‘doing what we do but doing it better’ she hopes to use this experience to contribute to improved outcomes for sick or preterm babies.

**Lecture Abstract:**
Volume-targeted ventilation is used widely but, despite this, different modes have not been compared using clinical outcomes. The latest Cochrane review published in 2010 (1) recommended that further research on neonatal ventilation should include comparisons of different volume-targeted modes. The VoluVent Trial is the first randomised controlled trial to compare two types of volume-targeted ventilation in preterm infants with respiratory distress syndrome (ISRCTN 04448562). This comparative effectiveness trial compared volume-controlled ventilation and volume guarantee using clinically relevant outcomes. Avea® ventilators were used to deliver both modes and deferred parental consent was used.
This talk will include details of The VoluVent Trial and its results as well as the challenges of undertaking complex interventions research within an intensive care setting. The use of deferred consent, the power of parent involvement in clinical trial design, and the remaining gaps in knowledge will also be discussed.

**References:**
## Biographical Sketch:

Charles Christoph Roehr (M.D., PhD.) is a neonatal intensivist and clinical researcher, currently Hon. Senior Clinical Lecturer at the John Radcliffe Hospital, Oxford University Hospitals, NHS Foundation Trust. His special interest is neonatal stabilization/resuscitation and non-invasive respiratory support.

Charles studied Medicine in Berlin, Germany. He had his Paediatric training in the UK (Oxford) and at the Charité University Medical Centre in Berlin. Following the completion of his research and teaching degree at the Charité (*Habilitation*), Charles spent almost 2 years as post-doc researcher and clinician with Professors S. Hooper and P. Davis in Melbourne, Australia (2012-14) before he took up his position at Oxford.

Charles is an avid researcher and a strong proponent of evidence-based neonatology. He has published over 70 peer reviewed scientific articles and is one of the guideline authors of the European Resuscitation Council (ERC) guidelines on neonatal stabilization/resuscitation.

On the European level, Charles is very active as officer of education, European Society of Neonatology (ESN) and council member and President-Elect of the European Society of Research (ESPR); he chairs the European Scientific Collaboration of Neonatal Resuscitation Research (ESCNR) and is the head of the European Respiratory Society’s neonatal and intensive care group (ERS Group 7.05).
**Lecture Abstract:**

“NOT all babies need to be sedated for intubation!”

I shall convince the audience that not all babies need sedation for intubation. My argument will be that contrary to common belief, using pharmacotherapy for intubating neonates in any instance may indeed not always be in the very best interest of our patients (Allegaert 2016). In fact, my honourable opponent’s claim that “Every baby should receive sedation for intubation” is a blunt generalization as it negates the patient’s perspective, which unquestionably will be circumstantial. The rigid claim for universal sedation might in fact remind the reader of the much cited “parachute experiment” where calls mandating the wearing of parachutes when jumping off planes were based on the assumption that those would be a prerequisite for preventing major trauma; however, as we now know, this paradigm has not ever been studied in any controlled setting and hence may be an overt generalization (Smith et al. 2003).

With regards to neonatal intubation, there have been until this day only a few randomised controlled trials (RCTs) investigating the efficacy, pharmacodynamics and hence safety drugs for intubation (Allegaert 2014). Nor is there enough published data to suggest that one agent, or in fact any combination of several pharmacological agents, provides safe and effective sedation and analgesia over another or in fact any other thoughtful combination. It is also noteworthy that few of the RCTs were actually ever designed or adequately powered to study mid- to long-term neurologic or systemic adverse drug reactions (ADR). Results from small scale RCTs have suggested significant ADRs. For instance Norman and co-workers have shown that premedication with morphine for neonatal intubation was associated with prolonged aeeG/ eeG depression, which was found independent of blood pressure changes (Norman 2013). Lastly, the circumstantial need for sedation (and analgesia) has not yet been fully explored nor have alternatives to pharmacological agents been much studied. To conclude, it often appears that the ubiquitous provision of pre-intubation pharmacotherapy might serve the doctor more than the patient. However, whilst it is invariably the patient who carries the consequences, it is always our first responsibility to “do no harm” (Smith C 2005).

**References:**

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<tr>
<th>Name:</th>
<th>Martin Elliott</th>
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<tr>
<td>Job Title:</td>
<td>Professor of Cardiothoracic Surgery UCL, Professor of Physic at Gresham College</td>
</tr>
<tr>
<td>Title of talk:</td>
<td>Learning from our Mistakes</td>
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**Biographical Sketch:**

I have been a consultant at GOSH since 1985, and hold the academic and teaching roles above. I have led many teams and was clinical director of a large division before becoming medical Director of GOSH from 2010 til 2015. I led the Quality and Safety team.

I have held and do hold several international visiting professorships, am widely published. I teach on the cabinet office leadership course, work with the Whitehall Industry Group and have advised health systems throughout the world. I work with many companies to improve teamwork and quality reporting. I am Chief Medical Officer of a Software company.

I am obsessed by the need for transparency in outcomes (working with international registries), and honesty in the reporting of error. My research has covered the pathophysiology of bypass, near infrared spectroscopy, outcomes analysis, and most recently tracheal transplantation.

**Lecture Abstract:**

The safety of the patient is paramount. Human error is normal. The NHS is labour intensive, and the number of interfaces between individuals and teams is huge. All these interfaces can fail.

In this lecture, I will explain these theoretical points and indicate how a transparent approach to outcome reporting, in real time, can influence behaviour for the better, trading on our competitive instincts.

I will also examine the negative consequences of blame, and discuss how organisations and units can encourage a just culture in which learning from error is the norm.

I will use real examples where appropriate and suggest methods which will work in any speciality.

**References:**

https://www.gresham.ac.uk/lectures-and-events/to-blame-or-not-to-blame-the-medical-profession-and-blame-culture

https://www.gresham.ac.uk/lectures-and-events/seeing-through-the-lies-innovation-and-the-need-for-transparency
### REaSoN 2017
### Speaker Abstract Pro-forma

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<tr>
<th>Name:</th>
<th>Glenys Connolly</th>
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<tbody>
<tr>
<td>Job Title:</td>
<td>Advanced Neonatal Nurse Practitioner</td>
</tr>
<tr>
<td>Title of talk:</td>
<td>Writing educational textbooks ~ Is it worth it anymore?</td>
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#### Biographical Sketch:
Glenys qualified as a general nurse in the 1970s and worked initially in adult coronary/ intensive care. She moved into children's nursing in the 1980s followed by neonatal care later that decade. In the 1990s she moved into nurse education and was responsible for, amongst other things, developing and delivering neonatal intensive care courses and contributing to midwifery and paediatric nurse training programs. She describes her nursing career pathway as a series of "happy accidents" as she never had a job plan and just took opportunities as and when they arose! Her career as an author began when she was approached by a publishing company to write a neonatal nursing textbook. The first edition was published in 2000, with the second edition in 2010. She has recently contributed three chapters to the 15th edition of the textbook Mayes' Midwifery (in print).

#### Lecture Abstract:
With the advent of the world wide web, information is instantly available at the touch of a button and long gone are the days of spending hours in the library hand searching journals for evidence to support essays, case studies and project work. So in this era of "easy" evidence and information is the textbook obsolete?

This session will discuss the who, why and wherefore of writing for publication and whether in this era of easy evidence it's actually worth it anymore.

#### References:
**Title of talk:** Care bundles to reduce CLABSIs in the Neonatal Unit

**Biographical Sketch:**
Vicky has worked clinically as an ANNP since her qualification in 2012. She is currently employed as an ANNP at the Princess Anne Hospital, University Hospital Southampton, where she works on the middle-grade medical rota, including the SoNET transport retrieval team. She is an independent nurse prescriber, and is currently completing a non-medical authorisation of blood products portfolio. Her interests are focused upon research, education and local quality improvement, and she has recently been involved in developing a care bundle aimed at reducing bloodstream infection rates. Vicky is also undertaking a Doctorate in Clinical Practice programme at the University of Southampton, which is focused on the implementation of care bundles to reduce neonatal bloodstream infections. She has received two professional bursary awards from the RCN Foundation Trust, as well as support for her project from the charity Bliss.

Her passion for sharing knowledge has evolved from clinical teaching to undertaking a secondment in 2014 with the University of Southampton, where she now teaches for 40% of her time on the Advanced Neonatal Clinical Practice MSc programme. In 2017, she completed her Post-Graduate teaching qualifications, and now helps to facilitate the neonatal Evidence-Based Practice module.

She has recently returned from Vietnam, where she worked for two weeks as a volunteer for the Newborns Vietnam scheme, helping to deliver clinical education and training for neonatal nurses.

**Lecture Abstract:**
Central line-associated bloodstream infections (CLABSIs) are associated with increased mortality, morbidity and prolonged hospitalisation. Complex interventions, such as care bundles, are interventions that have multiple interacting components, and have been shown to reduce CLABSIs in adult ICUs, demonstrated in the seminal Michigan Keystone project. Whilst this quality improvement work showed that zero CLABSI rates were achievable, attempts to replicate this success in the UK have had mixed success. The Matching Michigan study, whilst reducing paediatric CLABSI rates by 45%, failed to reach statistical significance, and this was felt to be due to variations and small numbers. However, this trial had challenges in out-performing the secular trend, and there were notable differences in team engagement.

This session will provide a critique of the current evidence on the effectiveness of care bundles to reduce CLABSIs in the neonatal unit, presenting the results of a systematic review and meta-analysis. It will outline the most common bundled elements used in these studies, and will consider how local teams may translate this evidence into local practice.
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<th>References</th>
<th>Details</th>
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</table>
**Name:** Dr Karen Luyt  
**Job Title:** Consultant Neonatologist, St Michaels Hospital  
**Title of talk:** Improving neurodevelopment by reducing sepsis: a quality initiative

**Biographical Sketch:**  
Karen Luyt was appointed as a consultant in neonatal medicine in 2004 and as Walport Senior Lecturer in 2009 with a research interest in brain injury and improving health outcomes in high risk infants. She works as a clinical neonatologist in the Regional Neonatal Intensive Care Unit at St Michael’s Hospital, Bristol.

**Lecture Abstract:**  
Very low birthweight (VLBW, <1500 g) infants are at high risk of infection during their stay in neonatal intensive care. Infections in VLBW infants have an additive detrimental effect on neurodevelopmental outcomes. VLBW infants are at increased risk of infection because of their immunological immaturity, exacerbated by intensive care interventions such as central venous catheterisation and ventilation.  

Blood stream infections remain a significant problem in NICUs around the UK. Recent UK Vermont Oxford data reports that 15% of VLBW infants in participating units develop one or more nosocomial infection. There is strong evidence that care bundles to reduce bloodstream infections in neonatal intensive care units can be very effective in preventing nosocomial infections.  

The presentation will focus on the successful implementation of the Cut Sepsis Incidence (CSI) QI project in a tertiary level NICU and the long term impact on neurodisability in this cohort of VLBW infants over a 10 year interval. The key learning points of our QI journey were the value of systematic benchmarking of outcomes and changing fatalistic attitudes around the inevitability of blood stream infections in sick VLBW infants.
REaSoN 2017
Speaker Abstract Pro-forma

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<th>Name:</th>
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<td>Job Title:</td>
<td>Senior Lecturer (Education)</td>
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<td>Resuscitation Education Package for the Multidisciplinary Team</td>
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**Biographical Sketch:**

Sharon Nurse has worked extensively within Midwifery and Neonatal education in the last 35 years in Northern Ireland; she is currently a Senior Lecturer in the School of Nursing & Midwifery in Queens University, Belfast.

Through collaborative curriculum design, Sharon strives to ensure that the highest standards of neonatal care are embedded in all midwifery and neonatal programmes provided by Queens University. This work has facilitated her involvement in committees and working groups within Maternal and Child Care across Northern Ireland.

Sharon's clinical and academic work in Midwifery and Neonatology is represented in her numerous publications and presentations at national and international conferences. Her special interests include neonatal resuscitation, newborn screening and neonatal palliative care.

**Lecture Abstract**

Midwives and neonatal nurses play a pivotal role in neonatal resuscitation and this is currently embedded in the pre-registration curriculum internationally; it is also a professional requirement of the Nursing & Midwifery Council (NMC, 2009). However, newly qualified staff (medical and nursing) can feel unprepared and anxious creating the need for new and sustained teaching strategies in life-saving skills training (Van der Putten, 2008). Resuscitation education and training can improve knowledge, confidence and preparedness for newborn management (Bull and Sweet, 2015) but this must be introduced at regular intervals in the healthcare curricula. Given that students may choose to study at home, at work or in the university, providing them with online films and interactive material enables them to access these tools at any time and use them repeatedly in developing their knowledge and confidence in neonatal resuscitation. Kenner (2016) endorses inter-professional education in the form of filming delivery of neonatal treatment with the team watching the film later and identifying areas for improvement.

An inter-professional education indicative in the form of filmed scenarios with questions following each section, has been developed by Midwifery Lecturers from the School of Nursing and Midwifery, a Neonatal Practice Educator, Neonatal Consultant and E-Learning Developer. Students were given the opportunity to learn about neonatal resuscitation through the use of interactive training films involving the multi-disciplinary team. In the pilot project the students accessed online films of neonatal resuscitation scenarios with accompanying questions. The two sessions were delivered to 2nd year Midwifery students and Post-registration Neonatal students in a computer suite within the university; evaluations of this teaching method were carried out using anonymous questionnaires (Anderson et al., 2017). Results were very positive and students felt there was added value in terms of self-learning and class discussions. Students commented on how studying the films had enabled them to pick up important points and practice issues often missed when watching neonatal resuscitation in the hospital setting. The setting provided safety and support which was reported as being very conducive to their learning.

**References:**


Nursing & Midwifery Council (2009) Nursing & Midwifery Council Standards for Pre-registration Midwifery Education. NMC: London
