**Abstracts**

**ENCOURAGING NEONATAL-MATERNAL BONDING: REDUCING SEPARATION DUE TO BORDERLINE CORD GASES**

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**Background** Poor cord gases are a well-known indicator of poor neurological outcomes in neonates, on which NICE Guidelines for Therapeutic Hypothermia are based. Currently, any baby with a cord gas pH <7.0 meets ‘Criteria A’, therefore any abnormal neurology (‘Criteria B’) noted can result in the infant being cooled for 72 hours to reduce long-term neurological injury.

Routine practice in East and North Hertfordshire Trust’s Neonatal Unit in 2018–2019 was to admit and perform 12 hours of neurological observation on any baby with cord gas pH <7.05, i.e. above the NICE threshold. A drawback of this is that otherwise well term babies are separated from their mothers for prolonged periods solely on the basis of cord gases, thus reducing neonatal-maternal bonding. In this study, the potential to reduce admissions of otherwise well babies with borderline cord gases is explored.

**Objectives** A quality improvement initiative to reduce admissions for term babies with borderline cord gases.

**Methods** BadgerNet, a program used to store information on all Neonatal Unit Admissions, was used to search for infants who were >37 weeks gestation and admitted due to poor cord gases. The search window was between 2018 to 2019. These infants were then reviewed, and their cord gases and neurological observations collated.

**Results** From our search we found 27 infants were admitted to the Neonatal Intensive Care for 12 hours of observations. Of these infants, only 1 went on to have abnormal neurology at 24 hours of age, after the observations had stopped. The subsequent MRI showed features consistent with mild-moderate HIE (see table 1).

Review of the infants with cord gas pH <7.00 showed 21% had no other reason for admission, i.e. they did not require intravenous fluids or respiratory support. Comparing this to the infants with cord gases between pH 7.00–7.05, this number increased to 69%.

**Conclusions** Over a period of a year, we found the majority of babies admitted due to borderline cord gases remained well and required no intervention. Accordingly, a change in...
practice which allows infants with cord gases between pH 7.00–7.05 to be monitored in transitional care, rather than being admitted to NICU, has been made. This represents an effective trade-off between clinical safety and promotion of neonatal-maternal bonding.

British Association of Child and Adolescent Public Health

PROVAC MOVEMENT-PROMOTING CONVERSATIONS ON VACCINE SAFETY

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Background Despite the overwhelming health benefits of vaccination some choose not to vaccinate due to concerns about their safety. Vaccine acceptance is a spectrum from complete acceptance to complete rejection with varying levels of hesitancy in between. While most people in United Kingdom have high level of confidence in vaccines and immunisation, there is a small population of families who are vaccine hesitant. Vaccine hesitancy has been described among the top 10 Global Health Care threats in 2019. Effective interactions between Health Care Professionals (HCP) can increase vaccine confidence and uptake.

Objectives What is the prevalence of vaccine related concerns in mothers attending antenatal clinics within our hospital?

Can education and awareness sessions for families improve their confidence in vaccine safety?

Can bespoke training and awareness sessions for HCP improve their confidence in having conversations on vaccine safety with vaccine hesitant families?

Methods

1. 147 questionnaires filled by antenatal mothers asking them about vaccine confidence and specific vaccine related concerns were analysed

2. 11 Bespoke ‘vaccine safety’ sessions for both HCP and families were undertaken. Vaccine confidence pre & post sessions were analysed.

3. Following positive results of the above sessions we are widening our scope further with help from the Regulation and Quality Improvement authority and Public Health Agency Northern Ireland to create and disseminate through our core team and identified Champions within 2 further Health and Care Trusts in Northern Ireland.

4. Given the slower progress of advances in treatment offered at the time, focus within the hospital turned instead to preventative action. Paediatricians and public health reformers united in opposition to institutionalised childcare. Instead, they encouraged maternal education surrounding infant feeding and childhood development norms.

5. Eventually, emphasis shifted to securing a ‘home-life’ for every child, resulting in a national investment in foster-care. Several organisations set up their own systems of placing children in homes. These were both praised and condemned by contemporary examination. More recent criticism of the larger organisations, through the perspectives of the children themselves, has revealed hundreds of incidences of neglect and abuse in these foster-homes.

Objectives

1. To situate the NCH’s history within the wider American child welfare movement

2. To examine the role of overlooked institutions in the Western foster-care movement

3. To evaluate the NCH’s Boarding-Out Department at the NCH in comparison with other foster-care systems

Methods First, I researched the American child welfare and Western foster-care movement by reading relevant secondary literature to gain an overview whilst also looking for gaps regarding the role of institutions.

Next, I examined the material at the New York Historical Society and Weill-Cornell archives to gain an understanding of the NCH, whilst contextualising its decisions using the secondary literature and discriminating material relevant to foster-care for inclusion.

Finally, I compared the NCH’s approach to foster-care with the wider movement. Using contemporary criticisms, I made