Department of
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Maternity Services Consultation

A Draft Maternity Strategy For Northern Ireland

September 2011

A Draft Maternity Strategy For Northern Ireland

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About This Document

This consultation document is being circulated to key interest groups, the Health and Social Care sector and other government departments. It is also available at: **www.dhsspsni.gov.uk/index/consultations.htm**

The Department is committed to effective consultation on this draft strategy and will make every effort to respond to the views expressed during the consultation process. Your response will help shape the proposed policy direction to ensure improved outcomes, services and support for women and babies in Northern Ireland.

A Draft Maternity Strategy For Northern Ireland

Foreword By Minister Edwin Poots

I am pleased to announce, for consultation, a new maternity strategy for Northern Ireland. The birth of a baby is a wonderful event and most women and their families in Northern Ireland experience high quality safe services. But more can always be done to improve our services and enhance the experience for all. Therefore, at the heart of this strategy is the need to place women in control of their own pregnancy and support them to make proactive and informed choices about their lifestyle and care in pregnancy, in order to secure the best possible health outcome for both mother and baby.

Improving outcomes starts early on in life with healthy lifestyle choices and effective antenatal, intrapartum and postnatal care based on the needs of the individual. Part of this is the communication of effective public health messages for women of child bearing age - particularly in relation to the potential adverse impact of obesity, smoking, alcohol and other forms of substance abuse. Being as healthy as possible before becoming pregnant is an important factor for all women of child bearing age to consider.

Research has shown that there can be considerable variation in maternity care. I want to reduce this variability by promoting, in the first instance, early direct contact of the woman with her local midwife who will ensure close liaison with her local GP. Following preliminary assessment, the woman will be supported by the midwife to make an informed decision regarding her antenatal care, and the place of birth for her baby. Most women will benefit from midwife led care but for some women, particularly those with complex needs, they will need consultant led care. In this context it is essential that such women have access to appropriate high quality services. So there is a balance to be made between the normalisation of birth against the early recognition of risks either to mother or baby or to both.

Promoting normalisation of birth through midwives taking the lead role in the care of straightforward pregnancies and labour will, over time, reduce unnecessary interventions, for example, caesarean sections. Whilst recognising such interventions are very valuable and in some cases can be lifesaving, all interventions in labour must be rigorously examined and benchmarked against comparable units.

I wish to thank Dr Paul Fogarty and Professor Cathy Warwick for co-chairing the review of maternity services and for developing this maternity strategy.

EDWIN POOTS MLA
Minister for Health, Social Services and Public Safety

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Preface by Co-Chairs

Maternity services in Northern Ireland aim to support women and to ensure the best possible start in life for their babies. This includes care from preconception advice through pregnancy, birth and the postnatal period. Continuing to achieve this aim will require reform and modernisation of our maternity services and a partnership approach with women throughout pregnancy to reduce the risk of complications.

The context in which we work is complex. We know that our western lifestyle is creating an epidemic of obesity, diabetes and heart disease. Many women also now start their families later in life. This means some women need more specialised care. On the other hand we also know that in certain instances we are using too many complex interventions. Currently our maternity care is largely concentrated in secondary units but we know that women like to have good quality care close to home.

The case for change in maternity services is compelling and widely accepted. All women deserve to receive care which is safe, both physically and emotionally. This means receiving the right care, from the right person at the right time in the right setting according to the woman's needs. Maternity services need to be delivered with an effective skill mix of staff which uses our highly trained workforce effectively and in a way which ensures best use of services. Most women will receive their care locally from their midwives and GPs. For high-risk women their care will be focused on Consultant Led Units supervised by senior medical staff on a 24/7 basis.

High quality care does not need to equate to hospital care for every woman. Indeed the growing complexity of healthcare means that it is impossible to provide specialist care for every condition in every hospital. Advances in science and technology offer new ways of tackling old problems and the internet and media provide an increasingly useful resource for health information. It is now possible for maternity services and the professionals who provide them to work in a highly integrated way without everyone being concentrated in a single building.

We must continually address how services are delivered to ensure a balance between local and centralised services. A networked model has the potential to ensure women receive appropriate care.

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This strategy is about the future, not the present. The aim is to focus medical expertise on those women who need it and extend the provision of other local services for women. We propose a network of maternity services in which the majority of women are cared for nearer to home, in which the skills of GP's, midwives and obstetricians are used appropriately, in which needs assessment, high quality communication and ease of transfer are paramount and where unnecessary interventions are avoided. The evidence from across the UK shows that this works for women.

Dr Paul P Fogarty
Royal College of Obstetricians & Gynaecologists

Professor Cathy Warwick
The Royal College of Midwives

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1. Maternity Care in Northern Ireland is of a high standard and as highlighted in the Regulation and Quality Improvement Authority (RQIA) report into Intrapartum Care[1] and in recent surveys carried out by the Patient and Client Council, most women here are satisfied with the standard of care they receive. There is, however, no room for complacency. Northern Ireland is a small region and while the safety of our services is noteworthy we need to be assured that we are tailoring our services to reach all sections of society while being realistic about how we can continue to provide high quality services to all women in a climate of continuously improving standards and safety guidelines in a more constrained financial climate.

2. Maternity care policy in Northern Ireland continues to be based on the policy circular issued in June 1996 "The Commissioning and Provision of Maternity Services: Policy Guidelines"[2]. This policy sets out the philosophy of care which should underpin the nature of maternity services provision and establishes policy objectives on Quality of Care, Safety, Choice, Communication, Control, Continuity of Care and Carer and New Options for Care. While this philosophy remains, it is clear that a lot has changed in the 15 years since that policy was developed.

3. While our maternity services are safe and of a high quality, we know from confidential enquiries and other research that significant inequalities exist in maternal and infant outcomes. We need to ensure that maternity services meet the needs of the socially disadvantaged as well as the advantaged. Our maternity services need to support families in progressive improvement in early child development through giving priority to antenatal and postnatal interventions that reduce adverse outcomes of pregnancy and infancy. Providing routine support to families through parenting programmes is an important element of any antenatal and postnatal service.

4. The wider public health agenda aims to promote healthy lifestyles and raise awareness of the benefits of healthy lifestyle choices. We know however that younger mothers, those over 40, those who live in a deprived socioeconomic area and mothers who are obese or come from a minority ethnic group are more likely to have poorer pregnancy outcomes. Levels of obesity are rising and there is strong evidence of the higher health risks for obese pregnant women and their babies. Reducing maternity obesity and improving preconception and pregnancy care for obese women could reduce deaths and illness in mothers and babies.

1 RQIA: Report on the RQIA Review of Intrapartum Care May 2010
http://www.rqia.org.uk/publications/rqia_review_reports.cfm

2 DHSS (HSS(SC) 1/96: "The Commissioning and Provision of Maternity Services: Policy Guidelines" June 1996
http://www.dhsspsni.gov.uk/hss-ghs-1996-01.pdf

5. Changes such as reducing smoking in pregnancy and increasing breastfeeding, would significantly improve the health of the woman and her baby. Providing additional support to vulnerable parents (for example through the Family Nurse Partnership) has been shown to make a significant long term difference to health and well being for children.

6. We need to capitalise on the good work of the Public Health Agency (PHA) through ensuring these public health messages reach all women and girls of child bearing age before they get pregnant. To be of most benefit, maternal health needs to be improved even before pregnancy begins. This way we can ensure women are as healthy as possible at the start of their pregnancy. **The Public Health Agency should ensure all women and girls of childbearing age are advised about emerging public health messages including the impact of obesity, smoking, alcohol and substance use on pregnancy.**

7. Women with existing conditions such as diabetes, epilepsy, cardiac disease or mental health problems will, in particular, benefit from good preconception care. This helps to ensure that their condition is being treated appropriately and the need for any change to medication is planned in advance of a pregnancy. **Women of childbearing age who have long term conditions, even those not planning a pregnancy, who are on regular medication or who have other risk factors should be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management. This should include the effect of their condition or medication on pregnancy and the baby.**

Antenatal

8. The majority of women in Northern Ireland contact their General Pracitioner (GP) when they think they are pregnant. Subsequently most women have antenatal care led by consultant obstetricians. Yet for many healthy women without complications there is no persuasive evidence that they need to be seen by an obstetrician. NICE guidance[3] confirms that routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise. In the future **when a woman becomes pregnant she should be facilitated to make early direct contact with a midwife as a first point of contact** who will ensure close liaison and communication with the woman's GP.

3 NICE clinical guideline 62 - Antenatal Care – Routine care for the healthy pregnant woman **http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11947**

9. Midwives will carry out booking and confirmation of pregnancy scans. The midwife will also assess the woman to ensure she receives the appropriate care in the antenatal period. This will mean **that each Trust must ensure it provides appropriate access to confirmation of pregnancy scans and and access to the Northern Ireland Maternity System (NIMAT system) in community settings.**

10. We must provide care that is targeted, appropriate and proportionate; therefore at every antenatal visit the midwife will carry out routine risk assessments to ensure the woman has not developed any risk factors that require her to be seen by an obstetrician or other professional and can continue to be cared for by a midwife who is the most appropriate professional for these women. **For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community.** Midwives should have the skills to establish which women need the specialist care of an obstetrician or other specialist and make direct referral to the appropriate specialist. **Women with complex medical or obstetric conditions will have care led by a consultant obstetrician.** The development of Early Pregnancy Clinics and Day Obstetric Units have proved to be a valuable contribution to the care of pregnant women and has resulted in fewer admissions to hospital for pregnancy related issues. However there are concerns about the appropriate use of these units. In the future if a woman has concerns about her pregnancy she **should be encouraged to contact her midwife if a problem develops to ensure only women who require to be seen by an obstetrician are referred to the day obstetric unit.**

11. There will also be a proportion of women who may require additional physical, mental or social needs and the midwife will be best placed to co-ordinate all the professional inputs to the woman's maternity care.

Antenatal Education

12. Currently while all maternity services provide antenatal education there is not a consistent approach across Northern Ireland. Antenatal education normally includes information on pregnancy, labour and parenting, but the content is decided locally and not all women or their partners choose to avail of this service. However this service provides an excellent opportunity to deliver public health messages, improve pregnancy outcomes and promote the health and development of the child. Therefore we need to ensure that while all families can benefit from parenting education we

specifically target those most in need of this support. The work that has been carried out over the last number of years on health inequalities and the information now available on outcomes for children and young people as a result of poor child health, the increasing rates of obesity, lack of educational achievement and other social issues makes a clear correlation between the early years of a child's life and their health and well-being throughout their lifetime. Good antenatal education is therefore vital to ensure we reduce the gap in health inequalities and prepare women and their partners for parenthood. **Trusts must put in place and encourage involvement in antenatal education which must be women centred and developed to ensure all women and their partners receive the advice they require to prepare them for parenthood as well as birth.**

Intrapartum Care (Normalising Birth)

13. At present in Northern Ireland, over 99% of women give birth to their baby in a hospital. Approximately 91% of babies are born in a Consultant Led Unit some of which provide the option of midwife led care. 8% of babies are born in Midwife Led Units either freestanding or alongside Consultant Led Units. Evidence from other UK countries[4] suggests that normalising birth results in better quality, safer care for mothers and their babies with an improved birth experience. Increasing normal births and reducing interventions is associated with shorter hospital stays, fewer adverse incidents and admissions to neonatal units and better health outcomes for mothers. It is also associated with higher rates of successful breastfeeding and a more positive birth experience. If we are to improve the quality and safety of care in the intrapartum period we need to normalise the birth process and minimise inappropriate interventions.

14. In the future all women will have a detailed assessment of need and should have the opportunity to have their baby in a place that is appropriate to their level of need, either at home, in a Midwife Led Unit or in a Consultant Led Unit. The decision regarding where is most appropriate for a woman to give birth will be kept under review and changed if required. **Women should be supported to make an informed decision about place of birth. Women with straightforward pregnancies should be encouraged to consider Midwife Led Units or home births.**

15. At present we have nine Consultant Led Units in Northern Ireland – three of which have stand alongside Midwife Led Units – and two freestanding Midwife Led Units. While at present this configuration of services provides

4 Promoting Normal Birth and NICE guidance
http://www.institute.nhs.uk/images//documents/BuildingCapability/HIA/4.Promoting%20normal%20birth.pdf

local access and some choice for woman not all women in Northern Ireland have the choice to give birth in a Midwife Led Unit. In the future we will expect **each Trust to provide at least one Consultant Led Unit which should have a Midwife Led Unit on the same site.**

16. Consistent safe, high quality obstetric services must be available to those who need them. Appropriately skilled and trained obstetric, neonatal and anaesthetic decision makers should be available on site to support consultant availability throughout the 24 hour day in Consultant Led Units. If we are to continue to provide accessibility to services while simultaneously sustaining and improving quality of care, changes to the current service profile may be needed. It is therefore proposed that each Trust in conjunction with commissioners carefully consider the sustainability of its maternity services in its current form. **Freestanding Midwife Led Units should be developed and maintained where there is an assessed need and the service contributes to sustainable maternity services.**

Interventions

17. Northern Ireland's maternity services have the same documented low rates of maternal and perinatal mortality and morbidity as the rest of the UK. However there is evidence of higher than average intervention rates when compared with other parts of the UK. Within the nine Consultant Led Units in Northern Ireland the rates of caesarean section for example varies between 23.8% and 35.4%.

18. Intervening when it is not necessary is not providing quality care and in respect of caesarean sections there is a growing body of evidence that it has an impact on future pregnancies, increasing both mortality and morbidity rates. It is therefore important that there is clear evidenced based senior clinical decision making for each intervention. While interventions can and do save lives, the variation in practice across Northern Ireland is not adequately explained.

19. The aim of "promoting normality" is to increase the normal birth rate and eliminate unnecessary intervention through midwives taking the lead role in the care of normal pregnancy and labour, focusing on informing, education and providing skilled support to women, especially first-time mothers and women who have had one previous caesarean section. **All Trusts must**

reduce inappropriate variability in practice by rigorously examining all intervention rates and benchmark against comparable units across Northern Ireland, the rest of the UK and Ireland.

Postnatal care

20. The potential to improve health and wellbeing for both mother and baby during the postnatal period is significant. The postnatal period begins with the birth of the baby and the vast majority of women want to go home as soon as possible after the birth and indeed there is no reason why these healthy women and babies should not be transferred to the care of a community midwife. This care will continue for at least 10 days following the birth. Throughout Northern Ireland there is considerable variation in the length of time spent in hospital following the birth of a baby. Timing of transfer home following birth in a Consultant Led Unit or Midwife Led Unit should be dependent on the clinical needs of the woman and her baby. Postnatal stays in hospital are becoming increasingly shorter and each Trust should benchmark their length of stay against comparable units across Northern Ireland.

21. During the postnatal period some dangerous complications of pregnancy can occur including bleeding, sepsis, thrombosis and mental health problems. The community midwifery team will play a vital role in supporting all women on their return home with their new baby. As well as monitoring the woman's general health at this time, the midwife could begin to address planning for future pregnancies. This postnatal period should be used as the preconceptual period for future pregnancies and public health information should be provided to the woman. A documented, individualised postnatal care plan incorporated into the Northern Ireland maternity hand held record should be developed with each woman.

22. This is also the time to support the woman in breastfeeding. More and more evidence points to the benefits – both in future health and in social terms – of breastfeeding. Maternity support workers are a new concept in Northern Ireland although have been used in other parts of the UK for some time. They are valuable members of the maternity team working with but not replacing midwives carrying out delegated tasks such as breastfeeding support to women in the community. **Postnatal care in the community should offer a home visiting schedule which is responsive to need for a period of not less than 10 days and include visiting by midwives and maternity support workers.**

23. This is also the time when professionals need to be alert to other social needs of the woman and her family, including domestic violence and safeguarding children, and be in a position to provide advice and support with information on parenting and local support networks. All women should receive the support they need to ensure their families and the new baby in particular, receive the best start in life. The woman's postnatal appointment with either her obstetrician or GP provides follow up care for this pregnancy, advice for the postnatal period and preparation for future pregnancies. **Women should be advised and encouraged to attend their 6 week postnatal appointment with the appropriate clinician.**

Communication and clinical leadership

24. High quality maternity care depends on good communication between professionals, an aspect of significant importance when urgent transfers are required between units and one in which difficulties have been cited in Northern Ireland and the United Kingdom when there have been serious adverse incidents in care. All units have now introduced the hand held record therefore co-ordinated regional development of its use should be easier. **Each Trust should ensure its maternity service shows good clinical leadership and communication including the use of the hand held record, Labour Ward Forum and other multidisciplinary groups.**

Quality measurements

25. In Northern Ireland each maternity unit monitors activity and outcomes to support continuous improvement. All Trusts contribute to a perinatal collaborative run by the Safety Forum which supports Trusts in their drive to provide safe care. With the introduction of monitoring tools such as the maternity dashboard and care bundles, regional outcomes to support continuous improvement should be more readily identified. Women's experiences should be included in any quality monitoring. **Work should progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.**

Information Technology (IT) support

26. The NIMAT system allows recording of a large amount of detail about the woman's past medical and obstetric history and details of her current pregnancy. However the system could be improved. Ease of information entry, ability to access the system in community settings, communication with other health information systems and retrieval of unit level data to support audit and service improvement are all areas where improvement is essential if we are to make best use of the technology available to us. Now that all units have introduced the NIMAT system, coordinated regional improvement to the system should be undertaken without delay. **The NIMAT system should be reviewed and updated to ensure coordinated regional data collection.**

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Full list of Recommendations

Recommendations

Recommendation 1: The PHA should ensure all women and girls of childbearing age are advised about emerging public health messages including the impact of obesity, smoking, alcohol and substance use on pregnancy.

Recommendation 2: Women of childbearing age who have long term conditions, even those not planning a pregnancy, who are on regular medication or who have other risk factors should be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management. This should include the effect of their condition or medication on pregnancy and the baby.

Recommendation 3: When a woman becomes pregnant she should be facilitated to make early direct contact with a midwife.

Recommendation 4: Each Trust must ensure it provides appropriate access to confirmation of pregnancy scans and NIMAT system in community settings.

Recommendation 5: For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community.

Recommendation 6: Women with complex obstetric conditions will have care led by a consultant obstetrician.

Recommendation 7: Women should be encouraged to contact their midwife if a problem develops to ensure only women who require to be seen by an obstetrician are referred to the day obstetric unit.

Recommendation 8: Trusts must put in place and encourage involvement in antenatal education, which must be women centred and developed to ensure all women and their partners receive the advice they require to prepare them for parenthood as well as birth.

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Recommendation 9: Women should be supported to make an informed decision about place of birth. Women with straightforward pregnancies should be encouraged to consider Midwife Led Units or home births.

Recommendation 10: Each Trust should provide at least one Consultant Led Unit which should have a Midwife Led Unit on the same site.

Recommendation 11: Freestanding Midwife Led Units should be developed and maintained where there is an assessed need and the service contributes to sustainable maternity services.

Recommendation 12: All Trusts must reduce inappropriate variability in practice by rigorously examining all intervention rates and benchmark against comparable units across Northern Ireland, the rest of the UK and Ireland.

Recommendation 13: Postnatal care in the community should offer a home visiting schedule which is responsive to need for a period of not less than 10 days and include visiting by midwives and maternity support workers.

Recommendation 14: Woman should be advised and encouraged to attend their 6 week postnatal appointment with the appropriate clinician.

Recommendation 15: Each Trust should ensure its maternity service shows good clinical leadership and communication including the use of the hand held record, Labour Ward Forum and other multidisciplinary groups.

Recommendation 16: Work should progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.

Recommendation 17: The NIMAT System should be reviewed and updated to ensure coordinated regional data collection.

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Chapter 1 – Strategic Context

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Outcome: To provide high quality safe, sustainable appropriate maternity services to ensure the best outcome for women and babies in Northern Ireland.

1.1 In Northern Ireland current policy on maternity services is set out in the policy circular, HSS(SC) 1/96, "The Commissioning and Provision of Maternity Services: Policy Guidelines", issued in June 1996[5]. The policy sets out the philosophy of care which should underpin the nature of maternity services provision and establishes policy objectives on Quality of Care, Safety, Choice, Communication, Control, Continuity of Care and Carer and New Options for Care.

1.2 Developing Better Services[6] (DBS) published in June 2002 set out plans for the future of Northern Ireland's acute hospital network. It also made recommendations on the location of Consultant Led Units. It recognised that a decreasing birth rate may lead to difficulties in maintaining the expert skills required in smaller hospitals with declining numbers of births. DBS recognised that in such units these small numbers of deliveries may make it impossible to sustain the full team necessary to deliver a Consultant Led Service. DBS also actively promoted the development of Midwife Led Units within or adjacent to Consultant Led Units.

1.3 A ministerial statement in July 2004[7] created the potential for the development of free-standing community Midwife Led Units, provided that all necessary support systems were in place.

1.4 Since the 1990's there has been growing support for women's choice of place of birth including Midwife Led Units and home births as a safe option for women with straightforward pregnancies. A quality maternity service is one which is both safe in terms of the physical and emotional needs of women and their babies, takes account of their opinions and experiences and one which also makes the best use of resources. We now need to look at how we deliver modern maternity services to each individual woman, respecting choice but ensuring the right care, by the right person, in the right place at the right time.

5 DHSS HSS(SC) 1/96, "The Commissioning and Provision of Maternity Services: Policy Guidelines", June 1996 **http://www.dhsspsni.gov.uk/hss-ghs-1996-01.pdf**

6 DHSSPS Developing Better Services June 2002

7 DHSSPS statement by Angela Smith Minister for Health, on foot of consultation on Community Midwife Units

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1.5 The methodology for the review, the Terms of Reference and a list of the project board members is attached at Appendix 1.

Need for change

1.6 Since the issue of the current maternity services policy in 1996 there have been considerable changes in the social, professional and financial environment. These changes are primarily as a result of increased emphasis on safety and quality; increased awareness of health inequalities; changing expectations of women and the need to address sustainability of services.

Safety and quality

1.7 Safety and quality underpins all health and social care services. The focus on safety and quality has several drivers including the outcomes of international research, the dissemination of best practice within and between systems and the increasing demand from the public for improvements in the quality of services. There have been major developments in evidence based guidelines over the past few years, many of which have been endorsed as best practice by the Department. The National Institute of Clinical Excellence (NICE) guidance will lead to more consistent evidence based practice.

1.8 Learning from Confidential Enquiries into Maternal and Child Health through the CEMACH reports has influenced both clinical practice and service organisation over the past few years. The National Patient Safety Agency (NPSA) leads on national initiatives to improve patient safety. Royal College standards and guidance are important indicators of professional best practice. The Regulation and Quality Improvement Authority (RQIA) has carried out important reviews since its establishment, including The Review of Intrapartum Care[8] published in 2010. This document highlighted key issues for further development, many of which are being addressed as part of this review. In addition through the Adverse Incident Reporting System lessons have been learned from a number of incidents over recent years and a learning ethos is being promoted throughout the service.

8 RQIA: Report on the RQIA Review of Intrapartum Care March 2011
http://www.rqia.org.uk/cms_resources/Southern%20Report%20Published%20Version%2011%20May%2010.pdf

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1.9 The Department's 10-year Quality Strategy[9] identifies quality under 3 main headings

- Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
- Effectiveness – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
- Patient and Client Focus – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

1.10 Evidence shows that a focus on normalising birth results in better quality, safer care and an improved experience for mothers and their babies[10]. Pregnancy and childbirth is not without risk and appropriate interventions can and do save the lives of mothers and babies. However interventions are not risk free and can be associated with complications both at the time and in the future. In the Department's Quality Strategy there is a clear commitment to safety - avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

1.11 For the future health and well being of women and their families we need to promote normality in pregnancy and childbirth. Clear senior clinical leadership will be required to change the current culture towards birth to one with a focus on keeping childbirth normal within the parameters of safe, high quality evidence based care. It is important that there is clear evidenced based senior clinical decision making for each intervention. In Northern Ireland intervention rates are higher than the rest of the UK and in Ireland. In the absence of persuasive evidence to support such a high caesarean section rate, units should be working to make their caesarean section rate comparable to those of the rest of the UK.

9 DHSSPS Quality 2020; A Ten Year Quality Strategy for Health and Social Care in Northern Ireland 2011
10 "Promoting Normal Birth" NHS Institute for Innovation and Improvement 2010
http://www.institute.nhs.uk/images//documents/BuildingCapability/HIA/4.Promoting%20normal%20birth.pdf

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Births and Interventions in 2009/2010

Country	Births	% Normal Deliveries	% Assisted Deliveries	% Caesarean Section	% Unknown Deliveries
Northern Ireland[1]	25619	55.6%	13.9%	30.2%	0.3%
England	652377	61.2%	12.0%	24.1%	2.7%
Wales	31583	61.0%	11.9%	26.6%	0.5%
Scotland[2]	57945	60.5%	13.4%	26.1%	0.0%
Ireland[3]	74278	61.0%	14.0%	25.0%	0.0%

Sources: Northern Ireland – Child Health System (HSS Boards) & KP19 Departmental Return; England – HES Online, Health and Social Care Information Centre; Scotland – SMR02, ISD Scotland; Wales – Statswales, Welsh Assembly Government.

Notes

1 Please note that the Delivery Percentages have been sourced from the Child Health System which is a live dataset and is subject to ongoing amendments and updating, therefore these figures may differ slightly from those previously supplied.

2 Figures shown for Scotland are for 2008/09. Information for 2009/10 (will be published in August 2011.)

3 **www.Bump2Babe.ie**

Increased awareness of health inequalities

1.12 The latest review of maternal deaths[11] shows for the first time in many years a small but very welcome decline in the overall maternal mortality as well as larger reductions in deaths from some clinical causes. In terms of overall public health the report also shows the first signs of a narrowing of the gap relating to pregnancy outcomes between the more affluent and most deprived women in the UK population. Stillbirth figures for Northern Ireland are not statistically different from the other 3 countries. The stillbirth rate is 4.7 per 1,000 live births in England, Wales, NI and Crown dependencies. Neonatal deaths in NI are 3.5 per 1,000 births, with the UK rate 2.8. The maternal death rate at 10.3 per 100,000 maternities is not statistically different from the overall UK rate of 12.1. There is no room for complacency however. While the health of the population as a whole has increased, there is evidence that disadvantage starts before birth and accumulates throughout life. If we can reduce health inequalities before, during and after pregnancy this will impact on the future health of our population. This can be at an individual level by encouraging and supporting women to make healthy lifestyle choices about smoking, alcohol, exercise and diet. In

11 Lewis, G (ed) 2011. Centre for Maternal and Child Enquiries (CMACE) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2006-2008. The Eight Report on Confidental Enquiries into Maternal Deaths in the United Kingdom: London: CMACE

addition there is evidence that some groups of women may need additional support due to physical, mental or social needs.

1.13 Becoming a parent is a major life event for the woman, her partner, family and the wider society. Within this social context maternity services should ensure a safe, positive and life enhancing transition to parenthood.

1.14 Pregnancy is a normal physiological process and for the vast majority of women is a safe life event. However changes in the maternity population mean some women, for example older women, women with pre-existing conditions and women with complex social needs, require additional support during their pregnancy. Care during pregnancy and birth has the potential to affect women physically and emotionally in the short and longer term. Therefore it is important that each woman's care is tailored to her physical and social needs.

Women's Expectations

1.15 Women's expectations are shaped to a large extent by the pattern of maternity service provision they have had in the past or family or friends have experienced. As part of this review the Patient and Client Council co-ordinated maternity service user engagement. A paper setting out the findings is attached at Appendix 5. When asked to identify priorities for improvement, users suggested the need for more staff, better continuity of care and better communication with mums before and after birth. Targeting of information to help women meet their personal requirements and improved staff attitudes was also another area suggested for improvement. Women also wanted to be able to see an obstetrician during their pregnancy, have shorter waiting times at clinics and be provided with more practical support with breastfeeding. Development of antenatal education to be more responsive to societal changes, and bereavement training for staff were also raised as issues. The views of users are essential in the delivery of maternity services and we welcome those views but we also have a responsibility to make sure the women are well informed about the services and the role of the professionals providing the services. Clearly if there is a lack of information about the role a midwife has in the care of women during pregnancy and birth then women may well expect to see a consultant at some point in her pregnancy.

1.16 Women should have the opportunity to make informed decisions, in partnership with their healthcare professionals, about the best care

for them and their baby. This decision making should be supported by evidence-based, written information tailored to the woman's needs. All information should also be accessible to women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English as their first language. Every opportunity should be taken to provide the woman and her partner or other relevant family members with the information and support they need.

Sustainability of Services / Professional issues

1.17 To ensure that our maternity services meet quality standards and provide high value evidence based care at all times we will need to review how and where services are provided. Maternity policy should focus on as much care as possible being delivered close to home but at the same time recognising that if more specialist care is needed this should be provided within a unit that meets NICE recommendations[12]. To ensure sustainability of intrapartum services there is a need to critically assess what should be provided and where across Northern Ireland. This assessment will need to recognise the vital interfaces with other services, especially anaesthetics and paediatrics. It will be for local determination to ensure a balance between local and specialist care is arranged.

Evolving roles within the maternity workforce

European Working Time Regulations

1.18 The European Working Time Regulations, amongst other measures, limit the average hours of work to 48 hours per week. Whilst the regulations have applied to most Health and Social Care (HSC) staff since 1998, they have only fully applied to doctors in training since 2009. Most maternity units now provide arrangements that comply with the regulations. This necessitates changes to traditional working arrangements for all staff involved in maternity care to address questions regarding safety, quality of care and training. The pressure on the workforce has been well documented and with the European Regulations on working hours and with increasing standards for professionals we need to ensure we have a workforce fit for purpose and adequate to meet the demands of the service

Recruitment and training for junior doctors

1.19 The reform to post graduate medical training has led to the introduction of competency-based training with an average length of training of seven years. Trainees move to a different training unit on a yearly basis and

12 NICE Guideline Intrapartum Care (CG55) September 2007 **http://guidance.nice.org.uk/CG55**

over the first five years of training will acquire core skills in obstetrics and gynaecology. In the final two years trainees are required to develop the special skills they will need to undertake their chosen career at consultant level. Therefore as they progress through the programme and gain more experience, there is a limit to the sites that can provide the higher level of training these doctors need to complete their training. Across the UK there have been problems with recruiting and retaining trainees in this specialty and Northern Ireland often has a number of vacant trainee posts, requiring the use of locums to ensure appropriate staffing within the service.

Consultant obstetricians

1.20 Over time the role of the obstetrician has changed, with increasing consultant presence now on the delivery suite. The consultant role in teaching has also evolved with a move from an apprentice model to more direct supervision and formal assessment of doctors in training. Consultants also need to be fully engaged in the leading of and participation in multi-disciplinary teams. They will also often have significant management or professional leadership roles.

Midwifery

1.21 Midwifery 2020[13] is a vital piece of work carried out on a UK wide basis It sets out a vision for the contribution that midwives will make in delivering high quality, cost effective and accessible services, working in partnership with obstetricians, GPs and Health Visitors. One of the key messages within the document is that for the majority of women with straightforward pregnancies all their care throughout their pregnancy will be provided by a midwife.

1.22 We fully endorse the key messages set out in Midwifery 2020. Midwifery 2020 reiterates the important role of midwives in the care they provide to women, babies and families and recognises the challenges and opportunities for midwives to develop their role as practitioners, partners and leaders in delivering and shaping maternity services. Midwives are highly trained professionals and we need to ensure the service makes maximum use of their skills to ensure the best care to women and also make best use of the unique resource that the midwife brings to the service. We must ensure midwives take responsibility for caring for women with a straightforward pregnancy in order to utilise their skills in the delivery of high quality maternity services as well as coordinating care for high risk women.

13 Midwifery 2020 Programme September 2010
http://www.midwifery2020.org/documents/MW2020_EXEC_SUMMARY_MS_WEB.pdf
http://midwifery2020.org.uk/documents/M2020Deliveringexpectations-FullReport2.pdf

Consultant Midwives

1.23 The introduction of consultant midwives will provide an expert practice function, education, training and development and professional leadership and should contribute to the development of professional practice through the promotion of evidence based practice, audit and standards of care. To date in Northern Ireland, two consultant midwives have been appointed by Trusts and the Public Health Agency has appointed a Midwife Consultant with a role in public health.

Maternity Support Workers

1.24 Midwifery 2020 also recognises the valuable place Maternity Support Workers have in the maternity team. Maternity Support Workers will be a valuable member of the maternity team but will not replace midwives and they will only undertake appropriate roles. It will therefore be vital for clear definitive roles and responsibilities and arrangements for delegation and supervision to be agreed to enable the service to make best use of these workers as well as providing a satisfying career choice for them. We need to ensure an effective use of the professionals' time and this is where maternity support workers can be of immense value to the team.

Maternity support workers can be of immense value to the maternity team, however clear definitive roles and responsibilities and arrangements for delegation and supervision should be agreed to enable the service to make best use of them as well as providing a satisfying career choice for them.

Configuration of services

1.25 Antenatal maternity services are currently provided in both hospital and community based settings, and almost all postnatal care is community based. The vast majority of intrapartum care is provided within acute hospitals in Consultant Led Units.

1.26 As we look to the future we must plan the specialised services which are needed to support obstetric care of women who have complex conditions or who develop complications. This will include critical care, anaesthetic, medical and surgical care, diagnostics, including radiology and laboratory services and paediatric services. What is becoming increasingly evident is that the spectrum of specialist support simply cannot be sustained on a 24/7 basis at nine sites. The provision of medical availability at birth varies between units however the RQIA report into Intrapartum Care confirmed

that NICE standards are still being met in all units in relation to the time required from decision to delivery by emergency caesarean section.

1.27 The sustainability of services will also be influenced by the need for the number of consultants and junior doctors required to provide 24/7 care while simultaneously meeting the requirements of the EU Working Time Regulation and NICE recommendations on availability of obstetricians, anaesthetics and paediatricians.

1.28 To ensure sustainability of intrapartum services there is a need to critically assess what should be provided and at what locations across Northern Ireland. Our current service provision makes it difficult to envisage how Northern Ireland can sustain maternity services based on eleven sites, nine of which are Consultant Led Units. Continuing to provide vulnerable services that are difficult to sustain is not appropriate as this does not ensure a safe high quality service in the longer term.

Interfaces

Role of primary, community and voluntary services

1.29 Across all stages of the maternity care pathway the role of primary care is important and for those women with particular requirements social services will be an important element of their care. Domestic violence often starts or presents during pregnancy and all professionals need to be alert to the potential for this to arise and to be aware of the local domestic violence services. The interrelationships with social services and health visiting particularly in relation to domestic violence and safeguarding children will be crucial for some women during pregnancy.

Role of Ambulance Services

1.30 Ambulance services will play a vital role in the safe transfer of women between units. Trusts need to engage with the Northern Ireland Ambulance Service (NIAS) to develop clear protocols for requesting and performing transfers either between different units within the Trust or between Trusts. Similarly, where proposals are being developed for reconfiguration of maternity services within a trust, the potential impact on the local and wider provision of ambulance services needs to be considered and addressed in conjunction with NIAS.

Private practice

1.31 There are a small number of women in Northern Ireland who have private obstetric care; however there is no private maternity hospital in Northern Ireland. Some women will have fully private maternity care, and others may choose to have some private antenatal care or investigations but give birth within the HSC. All women who are cared for within the HSC, whether or not they have received some previous private element of maternity care, must have care based on their clinical needs and best evidence and must not prejudice other women receiving care in the HSC. The care of all women must conform to relevant quality standards and the care of women receiving private care should be subject to the same audits as those receiving HSC care. In addition the private care should also be recorded in the unit's maternity dashboard.

Other acute services

1.32 Other services which interface with maternity services include gynaecology, paediatric/neonatal, anaesthetic and mental health services. While these services are not considered as part of this review it is important that good links are forged between the services to ensure the best quality care for women throughout pregnancy and following birth.

Mental Health Issues

1.33 An estimated one in 10 women may experience a mental health problem during or after pregnancy. It is therefore very important that signs of mental health conditions are identified early, and mothers given help and treatment as soon as possible. This will require good communication networks between maternity, primary care, social care and mental health services.

Gynaecological Services

1.34 Usually the same doctors provide the obstetric and gynaecology service, both at training grades and consultant level, and so these two services are closely related. The effect on training and the ability to provide effective medical cover including out of hours rotas for these two services need to be considered together.

Paediatric/neonatal services

1.35 Although midwives and obstetricians have skills in resuscitation and stabilisation of babies, Consultant Led Units which will deliver babies with additional care needs including prematurity will need additional neonatal provision. This will often be provided as part of the paediatric service,

with the same staff providing neonatal and paediatric medical care. Any changes considered will therefore need to consider the impact on both neonatal and paediatric services.

Anaesthetic services

1.36 Anaesthetic services form an integral part of the care delivered in Consultant Led Units. Obstetric services require a major anaesthetic input for services such as planned procedures and epidural pain relief. There is also a need for emergency provision including caesarean sections and other procedures needing anaesthetic, resuscitation or pain relief. Some women will also require intensive care. The obstetric component of anaesthetic services, especially out of hours, has to be considered as part of the wider anaesthetic service.

Maternity services do not exist in isolation from other services and it is important that interfaces between services are recognised and that partnerships between services are enhanced.

Improving the care pathway

1.37 NICE has issued guidance on antenatal, intrapartum and postnatal care[14] which have been endorsed by the Department and form the basis of our recommendations on the care pathway. A maternity service that supports families to achieve progressive improvement in early child development through giving priority to prenatal and postnatal interventions including parenting programmes, that reduce adverse outcomes of pregnancy and infancy is vital if we are to increase the life chances of future generations.

14 NICE Guidelines Antenatal Care (CG62) **http://www.nice.org.uk/nicemedia/live/11947/40115/40115.pdf**
Intrapartum Care (CG55) September 2007 **http://guidance.nice.org.uk/CG55**
Postnatal Care (CG37) **http://www.nice.org.uk/nicemedia/live/10988/30144/30144.pdf**

A Draft Maternity Strategy For Northern Ireland

Chapter 1 – Strategic Context

Summary

1.38 Maternity services in Northern Ireland need to be delivered in appropriate settings according to the woman's needs, using a highly trained workforce which embraces effective skill mix of staff and ensures best value for money from our services. The net effect of the changes to medical training will be a greater reliance on consultants and other career grade doctors for medical intervention when required. Our services need to reflect this in the planning and configuration of maternity care. We need now to consider how we can deliver all aspects of services – preconceptual; antenatal; intrapartum and postnatal to ensure that high quality sustainable services continue to be available and accessible to women in Northern Ireland.

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Chapter 2 – Preconception Care

Chapter 2 – Preconception Care

Outcome: Women are as healthy as possible at the start of their pregnancy.

2.1. Preconception care is any advice or management that occurs before a pregnancy. Currently in Northern Ireland preconception care including lifestyle advice and advice on starting folic acid if planning a pregnancy is generally provided by family planning clinics or general practitioners, often on an opportunistic basis. Women who are actively planning a pregnancy can and do access advice from a variety of services including their GP, family planning service and any specialist they attend for chronic conditions. These women generally actively seek the services available themselves. Midwives, Obstetricians, GPs and Health Visitors will often also use the postnatal period to give advice to women in preparation for their next pregnancy. Women who have underlying medical, social or mental health problems will also receive advice and support in preconception care from the professional responsible for their care.

2.2. Women who are planning a pregnancy may discuss this with their GP or family planning service, particularly if they are stopping the use of a contraceptive. Professionals will take this opportunity to give general healthy living advice about stopping smoking and reducing alcohol. The most common active preconception management is advising women who are planning a pregnancy to start taking small folic acid supplements. This is known to reduce congenital abnormalities such as spina bifida.

2.3. Some women have long term conditions that could impact either on the likelihood of getting pregnant or on a possible complication of pregnancy, for example, hypertension, diabetes, heart problems and epilepsy. Potential problems can be related to the condition itself or to the medications used to manage the condition. Specialists or GPs will be aware that women planning a pregnancy should have their medication reviewed and will be best placed to suggest medications based on pregnancy risks for any women of childbearing age even if they are not actively planning a pregnancy.

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Chapter 2 – Preconception Care

2.4. The Marmot Report[15] recognised that disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. That report sets out clearly that giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status.

2.5. The wider public health agenda aims to promote healthy lifestyles and raise awareness of the benefits of healthy lifestyle choices, to the whole population. These messages need to be targeted at women of childbearing age as changes will impact on their own health and on any pregnancy. We know that pregnancy outcomes are poorer for teenagers and women over 40, women who are obese or smoke and women who come from a minority ethnic group or who live in a deprived socioeconomic area.

2.6 Levels of obesity are rising and there is strong evidence of the higher health risks for obese pregnant women and their babies. Reducing maternal obesity and improving preconception and pregnancy care for obese women should reduce deaths and illness in mothers and babies. Reducing smoking in pregnancy should significantly improve the health of women and their babies. Preconception care is especially important for the small but increasing number of women becoming pregnant who have complex medical and social conditions.

2.7 In the future, a major challenge for health and social care professionals will be to ensure preconception planning advice is available to those women **not actively** planning a pregnancy. We know that not all pregnancies are actively planned, for example a recent CEMACH report[16] (Diabetes 2007) indicated that only around half of pregnancies were planned. In light of this women who are not really focusing on the possibility of pregnancy are more likely to be influenced by public health messages through general information or opportunistic advice from health professionals who they are attending for another reason. The Public Health Agency (PHA) provides information leaflets, for example on folic acid and there have been formal publicity campaigns about folic acid in the past, but none in recent years.

15 "Fair Society, Healthy Lives" – The Marmot Review - Strategic Review of Health Inequalities in England Post 2010
http://www.marmotreview.org/AssetLibrary/Exec%20sum%204.8MB.pdf
http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

16 CMACE Report 2007 Diabetes

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Chapter 2 – Preconception Care

2.8 Many of the lifestyle changes that are recommended to support a healthy pregnancy are in line with general public health advice. Stopping smoking and stopping the use of recreational drugs, achieving a healthy weight and limiting alcohol will reduce the likelihood of pregnancy problems for mothers and babies, but are also the advice given to the general population. NICE[17] guidelines on stopping smoking and weight management include specific preconception advice.

2.9 We need to capitalise on the good work of the PHA through ensuring these public health messages reach all women and girls of child bearing age before they get pregnant. To be of most benefit, maternal health needs to be improved even before pregnancy begins. This way we can ensure women are as healthy as possible at the start of their pregnancy.

Recommendation 1: The PHA should ensure all women and girls of childbearing age are advised about emerging public health messages including the impact of obesity, smoking, alcohol and substance use on pregnancy.

17 17 NICE Guidelines Quitting smoking in pregnancy and following childbirth Public Health Guidance PH26 June 2010 & Weight Management Before, During and After Pregnancy, Public Health Guidance PH27 July 2010
http://www.nice.org.uk/nicemedia/live/13023/49345/49345.pdf
http://guidance.nice.org.uk/ph27

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Chapter 2 – Preconception Care

2.10 The increasing numbers of women with long term conditions who may consider having a baby means that increasingly specialists and GPs will need to be in a position to provide information and management to support the best chances of a successful pregnancy. The guidelines produced by NICE[18] on mental health, diabetes and hypertension all include preconception advice.

Recommendation 2: Women of childbearing age who have long term conditions, even those not planning a pregnancy, who are on regular medication or who have other risk factors should be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management. This should include the effect of their condition or medication on pregnancy and the baby.

2.11 Women during and after pregnancy may be open to accepting advice and changing behaviours to the benefit of future pregnancies. Midwifery 2020 recognises the important public health role midwives can have in supporting women to make healthy decisions. It is particularly important for professionals involved in the postnatal period to recognise that this is also the preconception period for future pregnancies.

18 Nice guidelines – Antenatal and Postnatal Mental Health CG45 **http://www.nice.org.uk/nicemedia/live/11004/30433/30433.pdf**
Diabetes in pregnancy CG63 **http://www.nice.org.uk/nicemedia/live/11946/41342/41342.pdf**
Hypertension in pregnancy CG107 **http://www.nice.org.uk/nicemedia/live/13098/50418/50418.pdf**

Chapter 3 – Antenatal Care

Outcome: Every woman should have a positive experience of antenatal care and will receive her antenatal care from the right person in the right place at the right time – for the majority of women this will be provided by a midwife in the community setting.

3.1 Antenatal services cover all the care for a woman from when she discovers she is pregnant until she goes into labour. Throughout the antenatal period a woman will experience a first contact with her GP or midwife; a booking visit; antenatal visits; antenatal education classes and some women may also require additional support at an Early Pregnancy Clinic and/or Day Obstetric Unit or as an inpatient in hospital (see Para 3.13 - 3.15). NICE antenatal guidance states that pregnancy is a normal physiological process and that, as such, any interventions offered should have known benefits and be acceptable to pregnant women. Care during pregnancy should enable a woman to make informed decisions, based on her needs, having discussed matters with the health care professionals involved. The adoption of NICE guidelines for antenatal care by maternity services, and the introduction of evidence based regional hand held maternity record have encouraged a greater consistency of approach, but there are still significant differences in the way antenatal services are provided. We need to ensure a more consistent, safe approach to antenatal care to ensure all women receive care from the right person in the right place at the right time.

First Contact

3.2 At present in Northern Ireland when a woman discovers she is pregnant she contacts her GP to confirm the pregnancy and she is then referred for "booking" to the maternity unit of her choice. The GP or the midwife should give early information about folic acid; lifestyle choices and options for maternity care.

3.3 We tend to rely on women presenting to their GP when they become pregnant but there is more we can do to encourage and facilitate early diagnosis of pregnancy and booking before 12 weeks. It is particularly important to make maternity services accessible to those groups of women

who tend to book late. Direct access to midwives as first point of contact in the community is intended to increase the number of women making early contact with maternity services.

Recommendation 3: When a woman becomes pregnant she should be facilitated to make early direct contact with a midwife.

Booking Visit

3.4 This visit is usually the woman's first contact with maternity services and the purpose is to confirm pregnancy by ultrasound scan, take a full medical and social history from the women to assess her needs and carry out antenatal screening tests. In all Trusts women are "booked" on the Northern Ireland Maternity System (NIMAT), a computerised recording system. However, how and where this "booking" takes place varies between Trusts. For some women they must go to the hospital while for others the booking takes place in the community and they are referred to the hospital for the confirmation of pregnancy scan. Who women see at these visits also varies. In some Trusts the entire process is carried out by midwives while in other Trusts all women see a doctor at this visit. Most women have this booking visit when they are between 10 and 12 weeks pregnant.

3.5 At all times there should be clear communication between the woman, her GP, midwife and all the professionals involved in her maternity care. It is particularly important that the GP provides medical history to the maternity team at the start of pregnancy, and that the maternity team provides information to the GP at the end of the woman's maternity care.

3.6 In future the Midwife will arrange the booking visit which for the majority of women will take place in the health and care centre or a GP surgery. midwives will carry out booking and confirmation of pregnancy scans, ideally at the same time. This will mean that each Trust will need to consider the sites where it will provide access to ultrasound scans (for confirmation of pregnancy) and NIMAT. Ideally, the woman should receive her maternity hand held record at booking so that all professionals seeing her during pregnancy can write in the one record thereby improving communication and avoiding repetition.

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Chapter 3 – Antenatal Care

Recommendation 4: Each Trust must ensure it provides appropriate access to confirmation of pregnancy scans and NIMAT System in community settings

Antenatal Visits

3.7 Once the booking visit and risk assessment have been carried out a decision is made between the woman and her professional regarding the type of care she receives. The types of antenatal care currently available are

- Shared care, provided by GP and maternity team
- Midwife led care, provided by midwives
- Hospital only care, provided by obstetricians and midwives
- Private obstetric care, provided by an obstetrician

3.8 Currently most women in Northern Ireland have the majority of their antenatal care led by consultant obstetricians. The current services have developed in each area to address the different populations, geography and experiences of that service. While this has allowed flexibility it has also led to variation in practice that is not strongly evidence based. Currently in some areas across Northern Ireland women with straightforward pregnancies will attend midwives and GPs, but in other areas all women see an obstetrician, whether their pregnancy is complex or not. Where women are seen also differs across services, with some services being largely community based and others having more hospital clinics. Women may be seen by their GP, midwife and obstetrician in a poorly co-ordinated way leading to duplication of assessments, unnecessary travel and lack of continuity for the women. This can also lead to inefficient use of professional time, including consultants travelling to multiple clinic locations. We know from recent surveys that women indicated that travel to hospital and long waits at hospital clinics were negative experiences during their pregnancy.

3.9 For healthy women without complications there is no persuasive evidence that they require the attention of an obstetrician. As highlighted earlier women's expectations are shaped to a certain extent by the pattern of maternity services provision they or other family members have

experienced. While midwife led antenatal care is provided, the assumption that women should and need to be reviewed by an obstetrician is still prevalent. There is no reason why many women should need to attend busy hospital based antenatal clinics as their care is more appropriately delivered by midwives in the community. There will of course still be specialised hospital care for those women who need it.

> *"Having the same person looking after you throughout your pregnancy is good"*

3.10 We need to provide care that is targeted, appropriate and proportionate. This requires establishing which women need the specialist care of an obstetrician and which women can very appropriately be managed throughout their pregnancy by midwives who are skilled and experienced in monitoring and caring for women where their pregnancy is straightforward. It is important that the future of antenatal care in Northern Ireland is tailored to needs rather than perpetuating a pattern of care that while appropriate in a previous generation is no longer adequately responding to need.

Recommendation 5: For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community

3.11 Antenatal care should ensure early assessment of physical, mental and social risk factors and referral to specialist services if appropriate. Discussions regarding model of care/place of birth based on mother's choice plus on-going assessment of need are also appropriate as antenatal care progresses. At every antenatal visit the midwife will carry out risk assessments to assess the appropriate antenatal care. Where risk assessment identifies that a woman requires additional physical, mental or social care the midwife will refer as necessary and will be best placed to co-ordinate all the professional inputs to the woman's maternity care. Health Visitors will offer an antenatal review at home to all prospective parents after 28 weeks of pregnancy (or earlier if indicated)[19].

19 Healthy Child Healthy Future Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years. DHSSPS May 2010 **http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf**

3.12 Women with more complex pregnancies will see an obstetrician as well as midwives, and are more likely to have hospital antenatal care. This might be in specific clinics or as part of more general consultant antenatal clinics.

Recommendation 6: Women with complex obstetric conditions will have care led by a consultant obstetrician.

Early Pregnancy Clinics

3.13 Early Pregnancy Clinics have developed to provide rapid assessment, including ultrasound, of women in early pregnancy who develop signs or symptoms leading to concerns about the pregnancy. These clinics are usually attached to the gynaecology service, and may be staffed by nurses rather than midwives.

Day Obstetric Units

3.14 Day Obstetric Units were designed to provide a number of services such as fetal monitoring and clinical observations. This reduces the amount of time women have to spend as inpatients by allowing them to have careful monitoring or treatment for conditions such as pre-eclampsia, diabetes or hyperemesis while avoiding admission. These units also provide a referral service for midwives and GPs in the community who have concerns about a woman in their care. However these units can be inappropriately used which has led to increased activity in these units which puts undue pressure on other aspects of maternity services.

3.15 While it is important that those women who require the services of a Day Obstetric Unit have access to this, in the future the first contact for women with concerns during pregnancy should be her midwife who will be able to assess the problem and either provide treatment or refer as appropriate. All Consultant Led Units will have an Early Pregnancy Clinic and a Day Obstetric Unit which midwives as well as GPs or obstetricians will be able to refer women for further assessment or management.

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Chapter 3 – Antenatal Care

Recommendation 7: Women should be encouraged to contact their midwife if a problem develops to ensure only women who require to be seen by an obstetrician are referred to the Day Obstetric Unit.

3.16 A small number of women with complex problems will continue to need inpatient care and every Consultant Led Unit should continue to provide this service.

Antenatal Education

3.17 Currently all maternity services provide antenatal information[20] and education classes. These normally include information on pregnancy, labour and parenting, but the content is decided locally and not all women or their partners choose to attend these classes.

3.18 Good antenatal education is vital to ensure we reduce the gap in health inequalities and prepare women and their partners for parenthood. Uptake of antenatal education in Northern Ireland is variable; however there is an acknowledgement that while it is good in some areas it is clear we are not always providing classes appropriate to the needs of women and their families. We need to ensure we target antenatal education at those who will benefit most and that education classes are provided in partnership with the woman and the various professions and agencies.

3.19 Recent examples of antenatal education targeted at those with particular needs include The Family Nurse Partnership programme. This programme, while still being tested, is an intensive preventive programme for vulnerable, first time young parents that begins in early pregnancy and ends when the child reaches 2 years of age. The programme goals are to improve antenatal health, child development and parents' economic self-sufficiency. Evidence from other countries of the Family Nurse Partnership indicates benefits from specific education for specific families.

20 The Pregnancy Book Reproduced by the Public Health Agency with permission from the Department of Health (L). **http://www.healthpromotionagency.org.uk/Resources/children/pdfs/pregnancybook2004.pdf**

3.20 For other women for whom the Family Nurse Partnership may not be appropriate, we need to look at more innovative ways of ensuring women receive the evidence based information and education they require.

Recommendation 8: Trusts must put in place and encourage involvement in antenatal education which must be women centred and developed to ensure all women and their partners receive the advice they require to prepare them for parenthood as well as birth.

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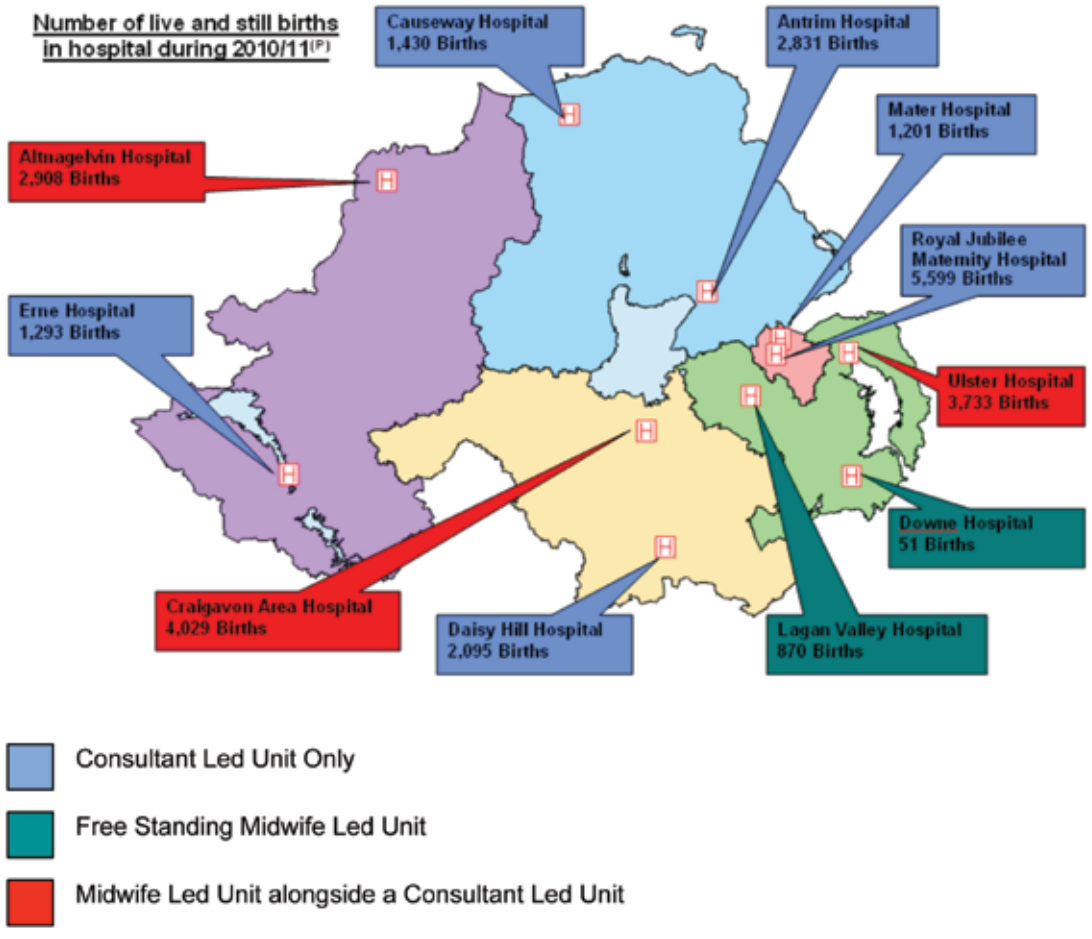
Chapter 4 – Intrapartum Care

Chapter 4 – Intrapartum Care

Outcome: Normalise the birth process and minimise inappropriate interventions in order to promote better quality, safer care and improved experience for mothers and babies.

4.1 In Northern Ireland in 2010 over 90% of women gave birth in a Consultant Led Unit, with less than 10% in a Midwife Led Unit and less than 1% at home. We currently have 9 Consultant Led Units - Altnagelvin, Antrim, Causeway, Craigavon, Daisy Hill, Erne, Mater, Royal Jubilee and Ulster Hospital - providing a range of options for birth from no interventions at all to births with epidurals, instrumental assisted deliveries and caesarean section deliveries.



P Data Relating to 2010/11 is provisional and may be subject to changes
It should be noted that Lagan Valley Hospital became a MLU from 2nd Feb 2011 therefore figures relate to consultant led and MLU for 10/11 year

4.2 There are five Midwife Led Units, three of which are adjacent to Consultant Led Units. These are in Altnagelvin, Craigavon and the Ulster Hospitals. There are two freestanding Midwife Led Units - in the Downe (from March 2010) and Lagan Valley hospitals (from Feb 2011). These Midwife Led Units provide care for women who have been assessed as requiring or likely to require little or no interventions while giving birth. Midwife Led Units tend to use a more active birth approach incorporating aids to support labour and birth such as birthing balls and water pools but also provide some medication for pain relief if women request it. Epidurals are not available in these units.

Choice of place of birth

4.3 Although the choice of place of birth has increased in recent years there are still variations in choice depending on where you live. For example, there are still areas where women do not have the option of having their baby in a Midwife Led Unit either freestanding or adjacent to a Consultant Led Unit. We need to consider how this can be addressed.

4.4 To date we have lagged behind the development of Midwife Led Units that have played a role in the delivery of care in other parts of the UK. Evidence shows that with appropriate care and support most healthy women can give birth with a minimum of interventional procedures. The NICE Intrapartum[21] guidance advises that women considering delivery in a non-Consultant Led Unit should be told they are less likely to have an intervention, however if complications arise she will need to be transferred to an Consultant Led Unit. While the evidence about the benefits of different planned places of birth is limited we do know that for women who are assessed as low risk there are benefits of delivering in Midwife Led Units.[22] During the course of this consultation further evidence may become available with the publication of the Birthplace in England Research Programme Study[23].

4.5 There is a need to support women's choice about where to give birth, including home birth, while ensuring that every woman and baby receives the appropriate care during labour and birth. The location for birth (including at home) should be discussed following careful assessment of need and risk and agreed between the woman and her lead professional in the antenatal period. While having a baby is a normal process it is important to realise that even with the best care sometimes tragedies happen within maternity services in all types of units despite best assessment. As with any other procedure risks and benefits of place of

21 Intrapartum Care (CG55) September 2007 **http://guidance.nice.org.uk/CG55**
22 The Cochrane Review **http://www2.cochrane.org/reviews/en/ab004667.html**
23 Birthplace in England Research Programme led by National Perinatal Epidemiology Unit at Oxford University **https://www.npeu.ox.ac.uk/birthplace**

birth must be explained to women (antenatally) to allow them to make an informed choice about place of birth.

4.6 The decision as to where is the most appropriate location for a woman to give birth should be kept under review, and can be changed should the woman's condition necessitate it. Protocols should exist for clear communication between all professionals involved in a woman's care to enable such a decision to be agreed and cascaded to those involved in her care.

Recommendation 9: Women should be supported to make an informed decision about place of birth. Women with straightforward pregnancies should be encouraged to consider Midwife Led Units or homebirth.

4.7 Our current configuration of maternity units means the majority of women are within one hour's drive of a maternity unit. We are aware that women value this rapid access to a professionally staffed unit for the birth of their child. We would support the continuation of this level of access for all women. Regardless of place of birth it is recognised best practice that women should have 1:1 midwife care in established labour. Northern Ireland has a good record of achieving this level of care and we must ensure we maintain this.

1:1 midwifery care in established labour must be maintained

Midwife Led Units

4.8 Clear protocols must be in place for assessment of suitability for giving birth in a Midwife Led Unit, and for effective stabilisation and transfer to an obstetric unit when necessary. NICE guidance states that if something does go unexpectedly seriously wrong during labour at home or in a Midwife Led Unit, the outcome for the woman and baby could be worse than if they were in the Consultant Led Unit with access to specialised care. Therefore clear protocols for stabilisation and transfer are essential.

4.9 Midwife Led Units will only admit women experiencing a straightforward pregnancy and birth and will follow criteria and guidelines agreed in line with NICE guidance. All midwives practising in Midwife Led Units whether freestanding or alongside must ensure their skills in dealing with

emergency situations are kept up to date and arrangements should be made with Consultant Led Units to allow rotation of staff to facilitate this. Similarly all midwives working within Consultant Led Units should rotate through Midwife Led Units in order to maintain their skills in promoting normality. This maintenance of emergency skills applies to all staff working in maternity services regardless of main place of work.

4.10 Robust emergency transfer arrangements need to be in place with the Northern Ireland Ambulance Service to ensure appropriate transfer for mothers and babies from freestanding Midwife Led Units to the nearest Consultant Led Unit.

> *"The Midwife Led Unit was excellent"*

Consultant Led Units:

4.12 Those women who are likely to require intervention from an obstetrician, anaesthetist or paediatrician during birth should be advised to give birth in a Consultant Led Unit. Consultant Led Units need to be able to provide care for women with complex needs.

4.13 While the numbers of births may be fluctuating there is increasing evidence that the type of women presenting for maternity care is changing. More women are having babies later in life, more women are obese when they get pregnant, and some women with other complex medical needs who may previously not have become pregnant are now requiring the service.

4.14 These groups all have increased needs therefore the pressure on services from more complex cases needs to be recognised and planned for in any capacity planning activity. NICE guidance[24] notes that Consultant Led Units provide direct access to obstetricians, anaesthetists, paediatricians and other specialist care including epidural analgesia. To ensure direct access to these specialist services will require a move towards enhanced consultant presence on the labour ward particularly at times of greatest risk. In order to provide best outcomes for women we need to take account of best evidence and each unit should have appropriate consultant presence for their workload obstetrician, anaesthetic and neonatal. However when consultants are not present on site they must be supported

24 NICE Guideline Intrapartum Care (CG55) September 2007 **http://guidance.nice.org.uk/CG55**

by resident doctors of at least ST3[25] competency. This will ensure 24 hour obstetric presence on labour wards, appropriate anaesthetic cover for analgesia, elective lists and emergencies in line with NICE guidance[26] (30 minute decision to delivery for emergency caesarean section)and appropriately trained paediatricians in case of neonatal problems at delivery. There should also be sufficient availability of midwives to ensure 1:1 care in established labour at all times. This pattern needs to take account of the role of Midwife Led Units in ensuring appropriate balance between local access to services and the need to provide more specialist care in units.

4.15 As a result changes in the profile of services cannot be avoided. It is proposed that each Trust in conjunction with commissioners carefully consider the sustainability of its maternity services. Where small units exist Trusts should examine whether the service is sustainable as a Consultant Led Unit and if not, consideration should be given to those units becoming freestanding Midwife Led Units, to ensure a sustainable balance between accessible local services and sustainable consultant led services. In some areas this may take time to implement and must be supported by steps to ensure that the capacity of Trust maternity units – Consultant and Midwife Led, is sufficient to respond to the needs of local women.

4.16 This may mean that those women whose pregnancy or delivery may be more complex, either as a consequence of maternal health, or anticipated infant complications, may need to travel further to access the professional expertise and specialised facilities required to provide the quality of care they need. Many women already travel to specialist units for intrapartum care, in the knowledge that the expertise and facilities they require is available at these specialist units.

Recommendation 10: Each Trust should provide at least one Consultant Led Unit which should have a Midwife Led Unit on the same site.

4.17 What we will move towards is a service model providing accessible local midwife led services or home delivery for those women for whom such care is appropriate and sustainable consultant led care for those women who need it.

25 A doctor at ST3 level, or equivalent, must have completed at least four years postgraduate training, of which,, at least two have been in the relevant specialty

26 NICE guideline (CG13) Caesarean Section April 2004

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Chapter 4 – Intrapartum Care

Recommendation 11: Freestanding Midwife Led Units should be developed where there is an assessed need and the service contributes to sustainable maternity services

Interventions

4.18 Just over half (55.3%) of births in Northern Ireland are normal births. While our maternity services have documented low rates of maternal and perinatal mortality and morbidity in line with the rest of the UK, there is evidence of higher than average intervention rates when compared with other parts of the British Isles, with almost 30% of births by caesarean section compared to 26% in the rest of the UK. There is also significant unexplained variation between units within Northern Ireland.

Modes of Delivery 10/11

Hospital	Births	% Normal Deliveries	% Assisted Deliveries	% Caesarean Section
Altnagelvin	2908	57%	15%	28%
Antrim	2830	54%	16%	31%
Causeway	1426	61%	13%	26%
Craigavon	4028	53%	13%	33%
Daisy Hill Hospital	2101	53%	14%	32%
Downe[2]	51	100%	0%	0%
Erne Hospital	1293	60%	13%	27%
Lagan Valley	869	78%	6%	16%
Mater	1195	62%	14%	25%
Royal Maternity	5494	51%	14%	35%
Ulster	3720	60%	13%	27%

Source: Child Health System[1]
[2]Downe MLU opened on 22nd March 2010.

4.19 While we recognise that interventions can and do save lives, the variation in practice between units within NI and in comparison with other parts of the UK is not adequately explained and requires further investigation.

Interventions can have an impact on future pregnancies, with a caesarean section in one pregnancy leading to increased rates of intervention and complications in subsequent pregnancies. A women's whole reproductive life should be considered as a continuum when agreeing care options.

Recommendation 12: All Trusts must reduce inappropriate variability in practice by rigorously examining all intervention rates and benchmark against comparable units across Northern Ireland, the rest of the UK and Ireland.

Support for women suffering stillbirth or neonatal death

4.20 The death of a baby is a devastating experience for the parents and family and the care they receive at this time can have a major impact on their perception of what happened and on their ability to cope into the future. The effects of grief can be overwhelming for parents and while good care cannot remove the pain poor care and insensitivity can make things worse.

> *"Personal touch is important. Being human and understanding when this has happened means so much to parents"*

4.21 Maternity staff can do a lot to ensure the memories parents have are as positive as possible but lack of training on how to support and care for grieving parents can leave staff feeling unprepared for this challenging time. The report carried out by the Patient and Client Council recommended that all staff, including medical staff, be given bereavement training as part of their role. All Trusts in Northern Ireland have bereavement co-ordinators who are available to provide training for staff as well as speak with patients who have been bereaved. All staff need to be aware of and take account of the Department's Care Plan for women who Experience a Miscarriage, Stillbirth or Neonatal Death[27] and the Department's Post Mortem Examinations – Good Practice Guide in Consent and the Care of the Bereaved[28].

All staff should receive bereavement training as part of their role

27 DHSSPSNI Careplan for women who experience a miscarriage, stillbirth or neonatal death **http://www.dhsspsni.gov.uk/hoi-careplan.pdf**

28 DHSSPSNI Postmortem Examinations – Good Practice Guide in Consent and the Care of the Bereaved **http://www.dhsspsni.gov.uk/postmortem.pdf**

Chapter 5 – Postnatal Care

Outcome: All women should be supported to ensure babies receive the best start in life.

5.1 The postnatal period begins with the birth of the baby and continues in hospital and then through transfer to the community. If the birth is uncomplicated most women now go home within 1-2 days of birth however this length of time varies across Northern Ireland. The table below highlights the variations in length of stay for vaginal birth and for caesarean sections. Length of stay for normal births varies from 0.7 days at Downe Midwife Led Unit to 1.9 days at the Erne and Altnagelvin Hospitals. Similarly for those women whose baby has been delivered by caesarean section the length of stay varies from 2.6 days at Lagan Valley Hospital to 4.9 days at Antrim Hospital.

Length of postnatal stay in hospital (2010)

Unit	Average length of stay for vaginal delivery (Days)	Average length of stay for caesarean section (Days)
Altnagelvin	1.9	2.9
Antrim	1.7	4.9
Causeway	1.7	3.8
Craigavon	1.6	2.8
Daisy Hill	1.5	3.0
Downe	0.7	N/A
Erne	1.9	4.4
Lagan Valley	1.4	2.6
Mater	1.3	2.7
Royal Jubilee	1.3	2.9
Ulster	1.3	2.8

NB: The Downe is a MLU and therefore does not carry out Caesarean Sections
These figures represent the mother's average length of stay between the baby's date of birth and mother's discharge date for 2010. Lagan Valley Maternity Unit became a MLU from 2nd Feb 2011

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Chapter 5 – Postnatal Care

Timing of transfer home following birth in a hospital or MLU should be dependent on the clinical need of the woman and her baby.

5.2 Within the hospital setting postnatal care is normally provided by midwives who will monitor the woman's clinical condition and will provide advice and support to new mothers on breastfeeding and parenting skills. As the majority of women who have a normal birth now go home within 24 hours women or babies on postnatal wards now have more complex needs than in the past. This requires midwives and medical staff to be more alert to complications on the ward and ensure these women are appropriately monitored. The opportunity to discuss their experience with women, especially any complications that arose, should also be taken at this time.

5.3 Responsibility for postnatal care following transfer from hospital lies with the primary healthcare team. This includes community midwives, general practitioners and health visitors. Most of the initial care is provided in the mother's home by community midwives who visit during the first 10 days after birth, after which the health visitor normally becomes involved in their care. The timing of handover from midwife to health visitor can vary depending on the needs of the mother and baby.

5.4 NICE guidelines on routine postnatal care of women and babies[29] sets out the routine or core care that every woman and baby should receive in the first 6-8 weeks of birth. In Northern Ireland Healthy Child Healthy Future[30] outlines the universal service provided to women during pregnancy and children until the age of 19. It is now becoming more normal to transfer women home from hospital within hours of the birth of their baby. With earlier transfers the role of the community midwife becomes increasingly important, responding to an infant's health issues, providing postnatal care, and importantly influencing health behaviours in anticipation of future pregnancies. While women both want and expect to be transferred to the community quicker than before, the shorter stay in hospital means we need to be aware of the potential increased workload for community midwives. With fewer women remaining in hospital for longer periods Trusts will need to consider how best to use the resources available to them and may need to focus more on the community especially as more antenatal maternity care becomes community based. However there will also need to be an awareness that those women who are remaining in hospital will have higher clinical needs and may require more interventions from midwives and doctors.

29 Nice Guidelines Postnatal Care (CG37) **http://www.nice.org.uk/nicemedia/live/10988/30144/30144.pdf**

30 Healthy Child Healthy Future Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years. DHSSPS May 2010 **http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf**

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Chapter 5 – Postnatal Care

5.5 The potential to improve health and wellbeing for both mother and baby during the postnatal period is significant. A recent UK survey of service users highlights inadequacies in the current provision of postnatal care. However the report compiled by the Patient Client Council for this review noted that women were particularly happy with the postnatal care they received from the community based midwifery team.

5.6 NICE guidelines on postnatal care[31] say women should be given information on potentially life threatening conditions including bleeding, sepsis and thrombo-embolism. While maternal death is a very rare event Saving Mothers' Lives[32] (2006-2008) noted that half of all deaths due to pulmonary embolism or bleeding and a third of all deaths due to infection occurred postnatally, including some cases several weeks after delivery. The majority of deaths related to mental health including suicide occur in the postnatal period. NICE recommends that at the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions for herself and her baby and to contact their health care professional immediately or call for emergency help if signs and symptoms occur.

5.7 Other key areas of postnatal care are the practical support with breastfeeding, general care of the baby and parenting advice. The midwife will also be monitoring the mother's mental health and putting her in touch with local support networks e.g. SureStart and breastfeeding support groups. There is strong evidence of the importance of parental interaction for infant brain development, "Healthy Child, Healthy Future"[33], reflects new evidence[34] that has emerged about neurological development and the importance of forming strong parent-child attachment in the first years of life.

5.8 Communication between the hospital of birth, the community midwifery team and the woman's general practitioner regarding her delivery and care needs following transfer home is essential to ensure the woman and her baby continue to receive the care they require. The woman should also be signposted and referred to other professionals if she requires more support, such as social workers and/or mental health professionals.

31 Nice Guidelines Postnatal Care (CG37) **http://www.nice.org.uk/nicemedia/live/10988/30144/30144.pdf**
32 Healthy Child Healthy Future Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years. DHSSPS May 2010 **http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf**
33 Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years. DHSSPS May 2010 **http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf**
34 Hosking, G. The hand that rocks the Cradle

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Chapter 5 – Postnatal Care

5.9 Prior to transfer from hospital a postnatal care plan will be agreed with the woman and updated as required. This should be included in the maternity hand held record that remains with the woman throughout her maternity care through to postnatal discharge in the community. Every woman should also receive "Birth to 5" book[35].

A documented, individualised postnatal care plan incorporated into the maternity hand held record should be developed with each woman.

5.10 Women should be aware that once they are transferred home, direct care continues mostly through the community midwifery team who will play a vital role in supporting the woman on her return home for at least 10 days after the birth. The community midwifery team will largely be midwives whom the woman has met during her pregnancy. The General Practitioner will also be available at this stage should any problems arise and good communication between the midwife and GP is essential. Transfer of the woman's care to the Health Visiting Service will take place when clinically appropriate but usually around 10 days. Again communication from the midwife to the health visitor is essential to ensure continuity of care for the women in the postnatal period.

5.11 Some women may need more support, and the community midwifery team should consider the use of maternity support workers. These support workers, under the delegation of a midwife, can provide help and support in a variety of practical areas such as bathing, feeding and skin care. For some women, a "drop-in" centre where a woman can discuss issues around breast-feeding or any minor concerns regarding her or her baby's health should be offered. The use of maternity support workers to assist midwives in the community along with the concept of walk in advice clinics could be methods of providing additional support for women while making best use of midwifery resources.

> *"Pregnant women are bombarded with information but little practical help is offered when the baby is born"*

35 Birth to 5
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_117167.pdf

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Chapter 5 – Postnatal Care

Recommendation 13: Postnatal care by the maternity team in the community should offer a home visiting schedule which is responsive to need for a period of not less than 10 days and include visiting by midwives and maternity support workers.

5.12 There is good evidence that breastfeeding improves the physical and emotional health of women and babies. We support the World Health Organisation's recommendations that babies should be exclusively breastfed for 6 months. The breast feeding statistics for Northern Ireland show that around two thirds (64% in 2010[36]) of women start breastfeeding their baby but that this number falls dramatically over the following few weeks. There is a review of the breastfeeding strategy for Northern Ireland which should be issued for consultation later in 2011, and all maternity units should respond to the recommendations in it. There are many reasons why women choose not to breastfeed or to give up breastfeeding after a short time and we need to ensure correct support is available to reduce these barriers. Midwives and health visitors have a strong role to play in this.

Women should be encouraged and supported to breastfeed their baby for up to six months and beyond

5.13 The woman's maternity care is completed after six weeks and at this stage she should have a postnatal appointment with either her obstetrician or GP whichever has been decided as being most appropriate. This visit provides follow up care for conditions which may have complicated the pregnancy eg. diabetes, hypertension, anaemia or mental health issues. The postnatal visit also provides an opportunity to screen for and counsel on postnatal depression.

5.14 The postnatal period is the ideal time to ensure planning for the next pregnancy bearing in mind that most women who have one child will have further pregnancies. This might include information on family planning, advice about preparing for future pregnancy and support for lifestyle choices including weight management, stopping smoking and healthy diet.

Recommendation 14: Woman should be advised and encouraged to attend their 6 week postnatal appointment with the appropriate clinician.

36 Infant Feeding Survey

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Chapter 6 – Supporting Modern Maternity Services

Chapter 6 – Supporting Modern Maternity Services

Outcome: Good Clinical Leadership and Communication to ensure high quality maternity service in Northern Ireland.

Support services

6.1 The previous chapters set out our proposals for improving the care pathway for mothers to be. While improvements to the care pathway are vital it is also important to ensure that we make best use of support systems currently in place to assist in monitoring and managing maternity services. These support systems such as those based on quality initiatives, communications and IT are important factors in the drive to improve services.

Communication & Clinical Leadership

6.2 High quality maternity care depends on good communication between professionals, an aspect of significant importance when urgent transfers are required and one in which difficulties have been cited in Northern Ireland and the United Kingdom when there have been serious adverse incidents in care. There are a number of areas where multi-professional communication is evident for example, most of the Trusts now report having a Labour Ward Forum which promotes multi professional communication within Trusts, and the monitoring of serious incidents to learn and change from them. Nonetheless communication between medical and midwifery staff is variable across Northern Ireland and steps to expand multidisciplinary collaborative working could yield significant improvements in provision of care.

6.3 Northern Ireland has a regional hand held maternity record which is now available for every woman. The record includes information based on NICE guidance for the woman as well as healthcare professionals. It is designed to be used by all professionals who see the woman during her pregnancy. However while it is intended that the record is carried by the woman from booking until she is discharged from the community midwifery team at the end of her postnatal care this is presently not consistently happening. All units have now introduced the hand held record therefore co-ordinated regional development of its use should be easier.

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Chapter 6 – Supporting Modern Maternity Services

Recommendation 15: Each Trust should ensure its maternity service shows good clinical leadership and communication including the use of the hand held records, Labour Ward Forum and other multidisciplinary groups.

Quality measurements

6.4 In Northern Ireland each maternity unit monitors activity and outcomes to support continuous improvement. Most units do this by way of a maternity dashboard however there are variations in how each unit measures outcomes which makes identification of regional trends difficult. The aim of maternity dashboards is to allow Trusts to benchmark their practice against themselves and by using a regional dashboard against other similar units. This would assist in reducing variability across Trusts in a number of areas, promote quality improvement and inform choice for women. All Trusts contribute to a perinatal collaborative run by the Safety Forum which supports Trusts in their drive to provide safe, quality care. Through the multi-professional and regional work of this group better communication and learning between professions and trusts has been enhanced.

6.5 With the introduction of monitoring tools such as the maternity dashboard and care bundles, regional outcomes to support continuous improvement should be more readily identified. Any quality monitoring must include patient experiences. Trusts, GPs and commissioners should continue to take full account of the findings and recommendations from confidential enquiries in commissioning and provision of services.

Recommendation 16: Work should progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.

IT support

6.6 The NIMAT System allows recording of a large amount of detail about the woman's past medical, social and obstetric history and details of her current pregnancy. However the system could be improved, including its ability to share data with other health service IT systems. Ease of information entry, ability to access the system in community settings, communication with other health information systems and retrieval of unit level data to support audit and service improvement are all areas where improvement is essential if we are to make best use of the technology available to us. Now that all units have introduced NIMAT Systems, co-ordinated regional improvement to the system should be undertaken without delay.

Recommendation 17: The NIMAT System should be reviewed and updated to ensure coordinated regional data collection

Chapter 7 – Going Forward

Outcome: The implementation of this strategy within the period 2011-2016.

7.1 Currently in Northern Ireland we spend over £87m on hospital maternity services and a further £11m on community midwifery services per year. In taking forward the recommendations in this strategy the Board and Trusts will be expected to make best use of the resources currently within the maternity service. Trusts will be expected to make best use of staff and use innovative ways to staff Midwife Led Units. In addition staff will need to be used flexibly within and between units moving from hospital to community and vice versa.

7.2 Over the past 7 years nearly £30m has been invested in maternity services infrastructure. This has enabled the service to rebuild and refurbish many maternity units to provide additional capacity and to establish Midwife Led Units. A further £50m is planned with the development of the new maternity hospital in Belfast. £35,000 has been or is being invested in IT infrastructure, specifically for the NIMAT system.

7.3 The Service will be expected to implement these recommendations within existing resources where possible.

Equality Screening

7.4 Equality screening has been carried out and it is considered that the introduction of this strategy will have no adverse impact on any of the groups mentioned in Section 75 of the NI Act 1991.

Next steps

7.5 The HSC Board and the Public Health Agency working with the Trusts and user groups will be expected to develop an Action Plan to take forward the recommendations in this strategy. Annual progress reports will be submitted to the Department by the end of March each year. It is anticipated that all recommendations will be fully implemented by March 2017.

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Appendix 1

Appendix 1

The terms of reference for the review and project board membership are as follows:

Terms of Reference

To review current maternity services and bring forward recommendations in the form of a regional strategy for the delivery of high quality, safe, sustainable, accessible, women centred maternity services in Northern Ireland.

Specifically the review will consider:

(i) The provision of services for women at each stage of their pregnancy, including antenatal care, intrapartum care and postnatal care with a particular focus on the contribution of Midwife Led Units, both stand alone and adjacent to Consultant Led Units, in providing high quality, accessible care.

(ii) The quality and safety of maternity services in the context of standards endorsed for use in the HSC sector and taking due account of other prevailing standards. *

(iii) The further development of an evidence-based approach to maternity services, providing informed choice and improving user experience at each stage of pregnancy, consistent with standards as in (ii).

(iv) Workforce issues, including training and skill mix of clinical staff, and the impact of the Working Time Regulations.

While this review will not specifically address related specialties it will take account of the interfaces between maternity services and other services including gynaecology, paediatric/neonatal, anaesthetic and mental health.

Methodology for the Review

A project board was established to take forward this review. The Board met on 7 occasions and visited each maternity unit during the months of July and August 2010. The visits provided the opportunity to hear at first hand the views of staff and issues relevant to their unit. In addition 3 work streams undertook detailed work on quality, user perspective and the workforce.

* The Project Board will take account of the RQIA report of 2010 and other relevant reports in developing the strategy.

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Appendix 1

Project Board Members

Co-Chair:	Dr Paul Fogarty (Royal College of Obstetricians & Gynaecologists)
Co-Chair:	Professor Cathy Warwick (Royal College of Midwives)
Member:	Dr Sanjeev Bali (Consultant Neonatologist & Chair Neonatal Network)
Member:	Mrs Eliz Bannon (Co Director of Maternity Services Belfast Trust)
Member:	Professor Martin Bradley (Chief Nursing Officer DHSSPS) (until 10th June 2011)
Member:	Dr Maura Briscoe (Director Secondary Care Directorate DHSSPS) (from 12th May 2011)
Member:	Dr Grainne Doran (Vice Chair NI Council Royal College of General Practice)
Member:	Mr David Galloway (Director Secondary Care Directorate DHSSPS) (until 30th Sept 2010)
Member:	Ms Maria Herron (Maternity Services Liaison Committee) (Mother's Voice) (alternative: Deirdre Gill)
Member:	Dr David Hill (Consultant Anaesthetist & Associate Medical Director South Eastern H&SC Trust) (Alternative: Dr Greg Furness Consultant Anesthetist Northern H&SC Trust)
Member:	Ms Maeve Hully (Patient & Client Council)
Member:	Dr Lorraine Johnston (Consultant Obstetrician, Northern H&SC Trust)
Member:	Dr Fiona Kennedy (Consultant in Public Health, Public Health Agency (PHA) (Alternative: Dr Brid Farrell) (Consultant in Public Health, PHA)
Member:	Dr Anne Kilgallen, (Medical Director Western H&SC Trust)
Member:	Dr Mary Murnaghan (Head of Obstetrics & Gynacology Northern Ireland Medical & Dental Training Association)
Member:	Mr Seamus McGoran (Director of Acute Services South Eastern H&SC Trust) (Alternative Mrs Eileen McEneaney)
Member:	Dr Miriam McCarthy (Deputy Secretary Health Care Policy Group DHSSPS) (until 28th Feb 2011) (& Director of Secondary Care DHSSPS until 11th May 2011)
Member:	Dr David McManus (Medical Director Northern Ireland Ambulance Service)
Member:	Mr Francis Rice (Director of Nursing Southern H&SC Trust) (alternative: Mrs Anne McVey)
Member:	Dr Nigel Ruddell (Assistant Medical Director NIAS)
Member:	Mr Dean Sullivan (Director of Commissioning H&SC Board)
Member:	Ms Verena Wallace Local Supervising Authority Midwifery Officer (LSAMO) (PHA)
Member:	Dr Paddy Woods (Deputy Chief Medical Officer DHSSPS)

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Appendix 1

Project Team

Member: Mrs Denise Boulter (Midwifery Officer DHSSPS)
Member: Dr Heather Livingston (Senior Medical Officer DHSSPS)
Member: Ms Siobhan McKelvey (Secondary Care Directorate DHSSPS to 30th Sept 10)
Member: Ms Joan Hardy (Secondary Care Directorate from 1st Oct 10)
Member: Mrs Margaret Rose McNaughton (Head of Regional Services Secondary Care Directorate DHSSPS)

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Appendix 2

Appendix 2

Maternity Pathway

(Based on NICE guidance and incorporated in antenatal, intrapartum and postnatal care, also incorporated in the maternity hand held record)

Preconception

All women should be aware of public health messages such as smoking, diet and alcohol on their health. Those women with specific medical conditions should have tailored preconception advice relating to their condition

8-14wks	Booking appointment. You will be offered an early ultrasound scan between 10 weeks and 14 weeks. Risk assessment to ensure appropriate care **Straightforward pregnancy**	
16-18wks	To review, discuss and record the results of screening tests undertaken, discuss fetal anomaly scan and reassess pattern of care. Risk assessment to ensure appropriate care **Straightforward pregnancy**	
18-20wks	An appointment with an Obstetric Ultrasonographer if you choose to have an ultrasound scan to detect structural anomalies. If your afterbirth is found to be covering the neck of your womb (cervix), you will be offered another scan at 32-34 weeks. Risk assessment to ensure appropriate care **Straightforward pregnancy**	
25wks	Antenatal examination (first baby only). Risk assessment to ensure appropriate care **Straightforward pregnancy**	
28wks	In addition to an antenatal examination, you may be offered a check for anaemia and antibody check. If your blood group is Rhesus Negative you will also be offered Anti-D. Risk assessment to ensure appropriate care Health Vistor offers an antenatal review at home **Straightforward pregnancy**	

Refer to obstetrician or other specialist

Complexity or risk identified → ← Risk managed

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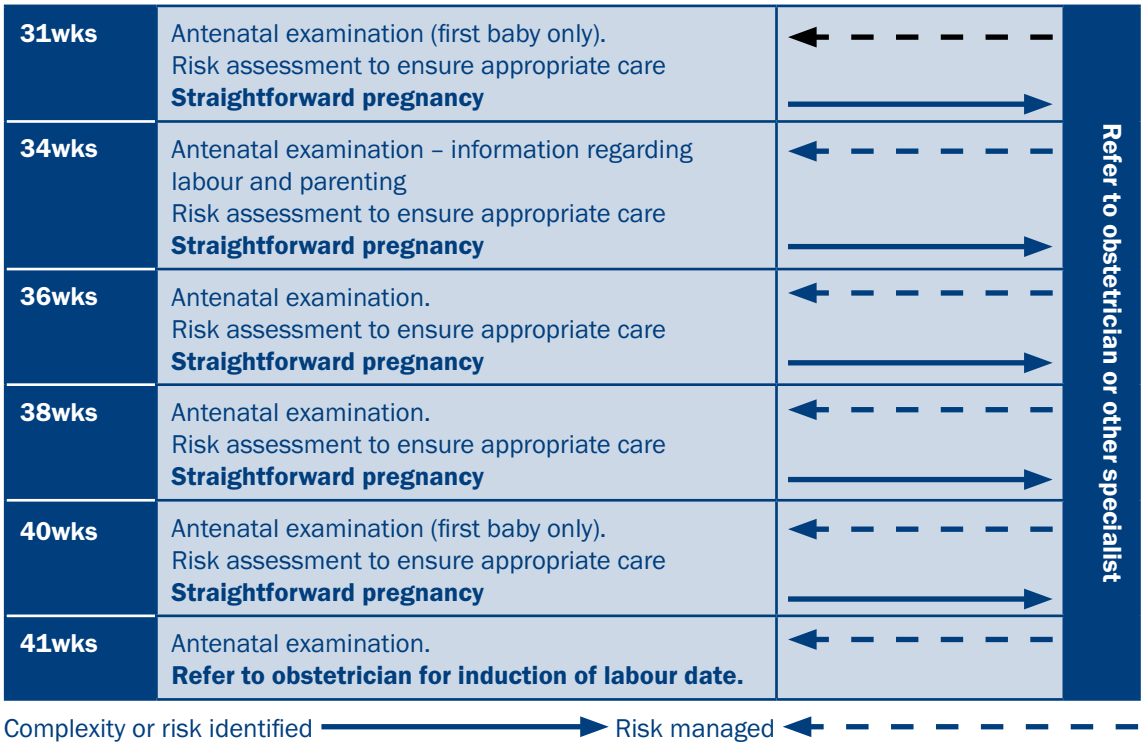
Appendix 2



Labour and birth:

If a woman goes into spontaneous labour at any stage after 37 weeks and she has undergone a straightforward pregnancy she should be encouraged to choose to give birth in a Midwife Led Unit either alongside or freestanding which ever is more convenient to her. If she requires induction of labour she should be referred to an obstetric led unit.

Postnatal care

Women who have had a normal birth with no complications should be well and wish to go home within 24 hours of birth and receive further support from their community midwife as required. For those women who require a longer stay in hospital due to clinical or social needs this should be facilitated ensuring she receives the appropriate care. Care in the community will be transferred to the Health Visitor when clinically appropriate, usually around 10 days. Good communication between the community midwife, general practitioner and health visitor is essential. At 6 weeks the woman will have her postnatal appointment with the GP or obstetrician.

Appendix 3

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Appendix 4

Standards and guidelines

NICE

The National Institute for Heath and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In 2006 DHSSPS entered an agreement to consider NICE guidelines for endorsement in Northern Ireland. NICE guidance has led to more consistent evidence based practice including the introduction of the maternity hand held record.

Confidential Enquiry into Maternal and Child Health (CEMACH)

The National Confidential Enquiries provide critical examination, by senior and appropriately chosen specialists, of what has actually happened to patients. Their recommendations have covered everything from individual clinical practice to national healthcare organisation. Learning from these reports has influenced both clinical practice and service organisation over the past few years.

NPSA

The National Patient Safety Agency (NPSA) aims to identify and reduce risks to patients receiving NHS care and leads on national initiatives to improve patient safety.

Royal College Standards and Guidance

Although not formally endorsed by the Department as benchmarks for commissioning the four Royal Colleges associated with maternity - Obstetricians and Gynaecologists, Midwives, Anaesthetists and Paediatrics and Child Health - either individually or jointly have issued a number of guidance and standards documents which are important for influencing clinical practice.

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RQIA

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland. The RQIA report for maternity services "The Review of Intrapartum Care" (2010) highlighted the key issues for future development in 5 areas:

- Staffing levels
- Effective clinical leadership
- Protected training time
- Use of information systems
- Standardisation of audit processes

Serious Adverse Incidents

Maternity services in Northern Ireland promote a learning ethos. Outcomes for mothers and babies are among the best in the United Kingdom. However lessons have been learned from a number of serious adverse incidents over the recent past leading to changes in service and practice, such as the use of physiological early warning systems after caesarean sections, the need for clear policies for transfer of care between lead professionals or units, and good communication between professionals, women and their families.

Appendix 5

Patient and Client Council

Summary Report of the Service User Engagement on the Strategic Review of Maternity Services August 2010

1. Background

As part of the strategic review of maternity services, the Patient and Client Council carried out a public engagement exercise with women and their partners who had recently accessed maternity services. The engagement took place in a variety of settings across Northern Ireland during July and August 2010.

The aim of the exercise was to ensure that the voice of mothers was embedded at an early stage of the strategic review so that the final document would truly reflect the experiences and opinions of users of maternity services. The full report on the service user engagement is available on the Patient and Client Council website **www.patientclientcouncil.hscni.net**

2. The process of engagement

Two engagement events were planned for each Health and Social Care Trust area. This included a focus group discussion with mothers and one other activity in each area targeting either pregnant women or those who had recently given birth. In total 131 mothers took part in the exercise in the following venues:

- Sure Start Strabane; Saol ur Sure Start, Whiterock; Portavogie Surestart, Ballymena Sure Start and Splash Surestart, Craigavon.
- Erne Hospital Maternity Unit Postnatal Ward, City View Medical Centre Baby Clinic in the Western Area.
- One to one interviews with mothers of premature babies facilitated through Tiny Life and a group discussion with the SANDS support group in the Southern Area.
- Antenatal clinic, Braidvalley Hospital in the Northern Area.

The discussion centred on five questions:

1. How happy were you with the overall service that you received?

2. Did you receive the information that you needed during the pregnancy? Was it easy to understand and practical given your circumstances?

3. What worked well about the care that you received? How could this have been improved?

4. Did you feel that staff caring for you, were able to meet your needs? Were you able to discuss problems with staff providing your care? Did you feel that you received continuity of care?

5. What would be your top priority for improving maternity services?

3. Main themes

a) In general participants were happy with the overall service that they received. This seems to be particularly true of community based midwifery care. Hospital care was reported as pressured and not offering continuity of care and messages. Lack of access to a consultant was a recurring theme.

b) General information given to women appeared to be adequate but there is a sense that women feel that they do not get information specific to their individual needs, particularly in the hospital setting.

c) The aspects that were reported positively included care in labour wards and community midwifery. Improvements suggested were better communication and greater engagement at all levels with mothers.

d) Lack of continuity and receiving of mixed messages from staff were raised as issues by service users. Staff attitude was commented on numerous times as making a positive difference when it was good as well as damaging if it was poor.

e) Asked to identify priorities for improving maternity services, the following were the main suggestions:

- more staff
- better continuity of care
- better communication with mums before and after the birth
- improved staff attitude
- being able to see your obstetrician during the pregnancy
- shorter waiting times at clinics
- more practical support with breast feeding
- bereavement training for staff including doctors.

4. Quotes from Mothers

As part of the engagement process there were many quotes from mothers which were pertinent to this work.

Here are some of them:

"Having the same person looking after you throughout your pregnancy is good"

Sure Start mother

"The Midwife Led Unit was excellent."

Comment from a mother at a clinic

"Pregnant women are bombarded with information but little practical help is offered when the baby is born."

Tiny Life mother

"Personal touch is important. Being human and understanding when this has happended means so much to parents,"

SANDS parent

Maeve Hully, Stella Cunningham
September 2010

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