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A Strategy for Maternity Care in Northern Ireland 2012 - 2018

July 2012

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 1



Contents

Foreword by Minister Edwin Poots, MLA		3
Preface by Co-Chairs		5
Executive Summary		7
Chapter One	Aim of Strategy	15
Chapter Two	Strategic Context	20
Chapter Three	Driving Change through Clinical Leadership, Workforce Development and Effective Communication	28
Chapter Four	Preconception Care	40
Chapter Five	Antenatal Care	45
Chapter Six	Intrapartum Care	53
Chapter Seven	Postnatal Care	64
Chapter Eight	Implementation	70
Appendix One	<i>Transforming Your Care</i> Summary of Key Proposals Relating to Maternity Services	77
Appendix Two	<i>Transforming Your Care</i> 12 Major Principles for Change	78
Appendix Three	Membership of Project Board and Team	79
Appendix Four	Maternity Pathway for Straightforward Pregnancy	82
Appendix Five	Bibliography	84
Appendix Six	Glossary, and National Standard Setting Organisations	89

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 2



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A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 3



Foreword By Minister Edwin Poots

The birth of a baby is a wonderful event, and most women and their families in Northern Ireland experience high-quality, safe maternity care.

A new-born baby needs the best start in life that its parents, society and public services can give it. This is because the general socio-economic, cultural and environmental conditions in which people live, as well as the lifestyle choices they make, their emotional health and other clinical and biological factors can all have an impact on the outcome of pregnancy for mother and baby.

This Strategy recognises the wider determinants of health and the links to the broader public health agenda. Concerted regional and local multiagency approaches to improve pregnancy outcomes and to reduce health inequalities for all women are essential. Through the provision of universal information, early intervention and support, parents and families can make better life choices, and will be better prepared for pregnancy, the birth of their baby and ongoing care.

History has shown us that high-quality maternity care significantly contributes to the health and well-being of the woman and her baby. Yet, more can always be done to improve our services and to 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 women and their partners to make proactive and informed choices about their lifestyle, self-care, and type of Health and Social Care (HSC) maternity service which will be appropriate to their needs.

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. Whatever the 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. We will work to ensure a culture of continual updating, so that all of our staff who deliver services are aware of the best evidence from research and have an opportunity to engage with researchers to get the evidence that may not yet be available.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 4



Promoting normalisation of birth through midwives taking the lead role in the care of straightforward pregnancies and labour will, over time, reduce unnecessary interventions, such as some caesarean sections. While 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 leading on the development of this Maternity Strategy. The Health and Social Care Board together with the Public Health Agency will lead on implementation with the formation of an action plan.

A handwritten signature in black ink, which appears to read 'Edwin Poots'. The signature is written in a cursive style and is located below the text of the Minister's statement.

EDWIN POOTS MLA

Minister for Health, Social Services and Public Safety



A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 5



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 hospitals, 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 well 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 prove 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's service 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.

This Strategy is about the future, not the present. The aim is to focus medical expertise on those women, with complex conditions, who need it, and to extend the provision of local services for others.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 6



We endorse a network of maternity services in which the majority of women are cared for nearer to home, in which the skills of GPs, midwives and obstetricians are used appropriately, in which needs assessment, high-quality communication and ease of transfer are paramount, where the best evidence from research is applied, 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





Executive Summary

Introduction

1. This document sets out the strategic direction for maternity care in Northern Ireland for the next six years. It follows public consultation in late 2011 when four workshops were held and 132 responses were received. The Strategy adopts an outcomes approach to maternity care; the six desired outcomes are:
 - give every baby and family the best start in life;
 - effective communication and high-quality maternity care;
 - healthier women at the start of pregnancy (preconception care);
 - effective, locally accessible, antenatal care and a positive experience for prospective parents;
 - safe labour and birth (intrapartum) care with improved experiences for mothers and babies; and
 - appropriate advice, and support for parents and baby after birth.
2. Each outcome is underpinned by a number of objectives which are documented throughout the Strategy.

Overview

3. Pregnancy is a normal physiological process, and for the vast majority of women is a safe event. Of crucial importance is that women should be as healthy as possible before considering pregnancy. That is why this Strategy links to a number of other public health strategies in order to promote, protect and improve the health and well-being of women and girls of childbearing age.
4. Some people are born into complex and difficult situations which can disadvantage them throughout their lives. Evidence shows that many of the determinants of health are complex and often interlinked. These include the general socio-economic, cultural and environmental conditions in which people live, as well as the lifestyle choices they make, their emotional health and other clinical and biological factors. All have the potential to contribute to adverse outcomes for the woman, her new baby and the wider family. This Strategy recognises that much can be done to improve life chances. Nevertheless, it needs a partnership approach, not just in health

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 8



and social care organisations and other government departments, but in society more generally.

5. Prospective parents are partners with Health and Social Care (HSC) staff in maternity care. They must be given the right information about how they can help themselves and their baby to stay healthy before and during pregnancy, and in the postnatal period. Early assessment in pregnancy and informed choice of location of birth of the baby, relevant to individual needs, are of crucial importance.
6. While maternity services in Northern Ireland are safe and of high quality, more needs to be done. 'Normalisation' of pregnancy and birth will improve outcomes for the mother and baby, and will enhance the personal experience for all involved.
7. Continuity of care is important. For women with straightforward pregnancies, the midwife will lead maternity care. For those with more complex conditions, the consultant obstetrician will lead care, with a greater presence of the consultant and senior doctors on the labour ward.
8. The location of maternity services will be configured in the context of population needs, changing evidence of best practice, and the principles outlined in *Transforming Your Care*¹. Co-ordinated commissioning, underpinned by local population plans, will change HSC service provision over the next 3-5 years. Each consultant-led unit will have an 'alongside' midwife-led unit. For consultant-led units, the interdependency with other specialisms is of vital importance in decision-making about location of units, for example, access to 24/7 anaesthetic and neonatal/paediatric care. The Northern Ireland Ambulance Service has a pivotal role to play in the safe transfer arrangements for women, particularly if complications arise in pregnancy; for example, haemorrhage, or a prolapsed umbilical cord requiring emergency intervention at an acute hospital.
9. Primary care professionals, particularly general practitioners (GPs) and health visitors are also partners in maternity care. There will be a communication protocol/pathway developed so that all professionals understand respective roles and responsibilities and that there is two-way sharing of information. The use of the maternity hand-held record will be expanded with an operating protocol put in place to facilitate its appropriate use.

1 HSC, *Transforming Your Care - A Review of Health and Social Care in Northern Ireland*, 2011.



10. Clinical leadership in maternity care will be promoted with greater involvement of Labour Ward Forums and engagement with Maternity Services Liaison Committees. A focus on quality and safety of service provision will be maintained through the development and use of the NI Maternity system (NIMATs), a regional maternity dashboard of quality indicators and involvement in national audit and research. All of the staff involved in the delivery of care will be supported to use the best evidence from research and/or to stimulate research and engage with researchers to find answers to questions for which the evidence is not yet available.
11. The following paragraphs set out a summary of each chapter.

Chapter One - This highlights the importance of giving everyone the best start in life through promoting and protecting the health and well-being of mother, baby, father, and family members. Some social, emotional and clinical factors have been identified which require concerted regional and local multiagency approaches to improve health outcomes for all and to reduce health inequalities. Investing in early intervention, prevention and support has been shown to have significant long-term benefits.

Chapter Two - This sets out the strategic context for the development of this strategy including the principles underpinning *Transforming Your Care*². Safety, quality and sustainability of service provision are essential to deliver the best outcomes for mother, baby and family. The promotion of 'normalising' pregnancy and birth is part of the quality and safety agenda. For those women who require specialist care, clinical interventions such as caesarean section, should be based on evidence of effectiveness and undertaken by skilled professionals in an appropriate clinical environment.

HSC commissioners of maternity care have a major role in critically appraising **what** services are best provided, taking account of population needs. HSC Trusts have an obligation to determine **how** best to provide these services within available resources. Prospective parents need to be considered as partners in care and given the information to make informed choices.

Chapter Three - High-quality care requires integration and communication across primary, community and secondary sectors with each professional understanding respective roles and responsibilities. The role of the voluntary sector in the support of parents is acknowledged. Effective



communication pathways will be put in place. Clinical leadership will drive change in maternity care and will be supported by a regional approach to quality improvement and by an ongoing commitment to the further development and use of information systems.

Chapter Four - Parents who are fit and healthy at the beginning of pregnancy generally have healthier babies. Some pregnancies are planned, many are not. A range of information and support needs to be available for all parents and a targeted approach to preconceptual care undertaken for those at greater risk of poorer pregnancy outcomes, including those with long-term clinical conditions and through increasing age, social factors and/or ethnicity.

Chapter Five - Early access to advice, information and appropriate support are vital components of good antenatal care. Most antenatal care should be delivered in a location which meets local needs. Risk assessment occurs throughout the antenatal period; those women with straightforward pregnancies will have midwives as the lead maternity professionals. For those with more complex pregnancies, consultant obstetricians will be the lead maternity professionals. Regardless of which professional leads, prospective parents should be seen as partners in care - that care being tailored to individual needs.

Chapter Six - This describes the current models of maternity service provision in Northern Ireland. Just over 55% of births are by normal vaginal delivery. There is unexplained variation in intervention rates when compared to other regions in the UK and Ireland. A culture of normalisation of birth has the potential to reduce unnecessary interventions and to improve the birthing experience for the parents, baby and family. Most women have good pregnancy outcomes and positive experiences but, sometimes, tragedies do happen. The importance of advice, information and support throughout the bereavement period is recognised.

Chapter Seven - There is variation in the length of stay in hospital following vaginal birth or caesarean section. Postnatal care could be improved upon. It is a real opportunity to provide information, and support to parents and baby. Breastfeeding will be promoted. Support will be tailored to individual needs; for example, in regard to future pregnancies and sexual health, clinical conditions, and emotional health. The maternity team will offer postnatal care in the community. This will be a woman-centred home visiting schedule for a period of not less than 10 days and will include



visiting by midwives and maternity support workers. Women will be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician.

Chapter Eight - This chapter details implementation and accountability arrangements. Given the importance of translating policy into practice, the following paragraphs represent a summary of how this will be achieved.

Implementation

12. The Health and Social Care Board (HSCB) and Public Health Agency (PHA) will co-lead the implementation of this Strategy. They will work with local health economies to include Local Commissioning Groups (LCGs), HSC Trusts, primary care practitioners, and other providers of maternity care. The HSCB/PHA will be responsible for development of a regional Action Plan using the twenty-two objectives identified; these are linked to the six outcomes as identified in paragraph 1 of the Executive Summary. Each objective will require the Board/PHA to develop a number of actions. Improvements should be made in line with the best possible, up-to-date evidence from research. Performance measures to demonstrate improvement in service provision and outcomes for women and the wider family circle will be a necessary part of the Action Plan.
 13. It is essential that each HSC provider plays its part in the implementation of this strategy. A real opportunity exists through HSC Trusts and other provider organisations to work together to improve outcomes for women and their babies. It is envisaged that the multidisciplinary Integrated Care Partnerships (ICPs) including GPs, hospital clinicians and community health providers, as proposed within the *Transforming Your Care*, would facilitate more integrated and effective ways of working.
 14. The twenty two objectives are outlined below. Chapter Eight provides the full details of outcomes and objectives, and how they link with examples of performance measures. DHSSPS expects an Action Plan to be submitted to the Department by the HSCB/PHA by January 2013. Progress towards completion of this Plan will be the responsibility of the HSCB/PHA, working with providers through collaborative partnerships. Progress on implementation of the Action Plan will be monitored through routine accountability arrangements.
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Objectives

15. The objectives are:
1. A universal approach to major public health messages for women and girls of childbearing age will be promoted. This includes the importance of healthy life styles, and a focus on the social factors and clinical conditions which are known to have an adverse impact on outcomes for mother and baby.
 2. A culture of 'normalisation' of pregnancy and birth will be promoted as part of population planning and the commissioning and provision of maternity care. The principles outlined in *Transforming Your Care* will inform how access to maternity services and maternity care is best promoted and provided.
 3. Prospective parents will be considered as partners in maternity care and given all relevant information, in appropriate formats, to make informed choices about what is best for them and their baby.
 4. A maternity communication protocol/pathway will be developed outlining the principles for communication and information sharing across the primary, community and hospital interface. As part of this process, each should understand respective roles and responsibilities especially on 'who' and 'how' a pregnant woman contacts the health service in the event of a concern or clinical emergency.
 5. Maternity services must show good clinical leadership and communication, including in the use of the maternity hand-held record, Labour Ward Forum and other multidisciplinary groups.
 6. Work will progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.
 7. The NIMAT system will be continually reviewed and updated to ensure it is 'fit for purpose' to promote coordinated regional data collection, in line with data protection principles and information governance.
 8. Women of childbearing age who have long-term conditions, even those not planning a pregnancy, who are on regular medication or
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who have other risk factors will be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management.

9. A clear pathway of care will be available for individuals with long-term conditions who are planning a pregnancy and throughout the pregnancy.
 10. When a woman becomes pregnant she will be facilitated to make early direct contact with a midwife.
 11. There will be appropriate access to booking scans and the NIMAT system in community and non-acute hospital settings.
 12. For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the local community.
 13. Women with complex obstetric conditions will have care led by a consultant obstetrician.
 14. Women will 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 Maternity Assessment Unit.
 15. Antenatal education will be enhanced and active involvement of prospective parents will be encouraged; this education will primarily 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 for birth.
 16. Women will be supported to make an informed decision about their place of birth by providing a balanced description of the benefits and risks of the different types of maternity settings. This will include information on midwife-led units, homebirth and consultant-led units.
 17. The HSC will consider how best to maximise choice in intrapartum care while also meeting other key priorities and statutory obligations. A networked approach to maternity care, with cross-boundary flows between HSC organisations, and possibly other jurisdictions, will be necessary.
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A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Page 14

18. Where a consultant-led unit is provided, a midwife-led unit will be available on the same site. As well as providing services for the local population, the Belfast Trust will provide the regional centre for Northern Ireland to care for the most complex cases.
 19. Freestanding midwife-led units will be considered as an option for the provision of accessible, high-quality, sustainable, and effective maternity care.
 20. Inappropriate variation in practice will be reduced by examining all intervention rates, and benchmarking against comparable units across Northern Ireland, the rest of the UK and Republic of Ireland.
 21. Postnatal care, provided by the maternity team in the community, will offer a woman-centred home visiting schedule which will be responsive to need for a period of not less than 10 days and will include visiting by midwives and maternity support workers.
 22. Women will be advised and encouraged to attend their six-week postnatal appointment, with the appropriate clinician(s).
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Chapter One - Aim of the Strategy

Outcome: Give every baby and family the best start in life.

Introduction

- 1.1 Pregnancy is a normal physiological process, and for the vast majority of women is a safe event. Becoming a parent is a major life event for the woman, her partner, and family. Within this social context maternity services must promote a safe, positive and life-enhancing transition to parenthood.

Definition of Maternity Services and Care

- 1.2 For the purposes of this document, 'maternity services' refers to professional care delivered to women, their partners and fetus/baby in the preconceptual, antenatal, labour and birth (intrapartum), and the postnatal period. These maternity services are provided by professionals in their field, including midwives, obstetricians, anaesthetists and neonatologists/paediatricians. 'Maternity care', on the other hand, is a broader concept and refers to care provided throughout the maternity pathway. This can be delivered through various models of care - by maternity professionals (as identified above) and by primary care professionals, including GPs and health visitors. Both the maternity professional and generalist practitioner have roles and responsibilities to ensure that maternity care is person and family-centred, meets individual needs, and is delivered in the right place, at the right time, and by the most appropriately skilled person.

Aim of Strategy

- 1.3 The aim of this Maternity Strategy is to provide high-quality, safe, sustainable and appropriate maternity services to ensure the best outcome for women and babies in Northern Ireland. In doing so it is recognised that all health and social care staff and members of the public must work together if health and social care maternity outcomes are to be improved, not just for mother and baby, but for both parents and the wider family. This is because clinical treatment, emotional care and social factors are inextricably linked during a woman's pregnancy. It is also important to



recognise that, for some members of society, disadvantage starts before birth and can increase over the course of their lifetime.

- 1.4 Health inequalities are differences between sections of the population which occur as a consequence of disparity in social and educational opportunities, financial resources, housing conditions, nutrition, employment, and access to health services. In other words, inequalities in health outcomes are wholly or partly a result of differences in the wider social determinants.
- 1.5 Action on health inequalities requires action across all the social determinants of health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage³. This, therefore, must be an integral part of improving maternity service provision for all women throughout their:
- preconceptual care;
 - antenatal care;
 - labour and birth (intrapartum care); and
 - postnatal care.

Reducing Inequalities in Maternity Care

- 1.6 Health inequalities in the antenatal phase can arise for many reasons, but are largely dictated by social factors. The National Institute for Health and Clinical Excellence (NICE) *Clinical Guideline (CG) 110, Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* (2010) highlights complex social factors that may adversely impact on pregnancy outcomes and increase the risk of maternal death. In particular, four areas were highlighted, which complement findings in other reports:
- women who misuse substances (alcohol and/or drugs);
 - women who were recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English;
 - young women under the age of 20; and
 - women who experience domestic abuse.



Other factors which may increase maternal death include being single, unemployed or in a relationship where both partners are unemployed, living in deprived areas, and the family being known to child protection services.

- 1.7 Infants of women living with complex social factors have an increased risk of dying during the perinatal period. This complements the findings of the Confidential Enquiry into Maternal and Child Health (CEMACH), *Why Children Die: A Pilot Study*⁴, which states that “children born to women from more vulnerable groups also experience a higher risk of death or morbidity and face problems with pre-term labour, intrauterine growth restriction, low birth weight, low levels of breastfeeding and higher levels of neonatal complications”.
- 1.8 In addition to social factors, genetic and biological factors also contribute to high-risk pregnancies; these factors are often interlinked, such as:
- the relationship between diabetes, obesity and poor nutrition;
 - teenage pregnancy, smoking, alcohol and poverty; and
 - gender-based violence, substance misuse and poor mental health.
- 1.9 The latest review of maternal deaths⁵ 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, this review also shows the first signs of a narrowing of the gap relating to pregnancy outcomes between the more affluent and most deprived women in our population.
- 1.10 Stillbirths, neonatal deaths and maternal deaths in Northern Ireland are not substantially different from the other three UK countries. The rates in Northern Ireland are: still births 4.7 per 1,000 births; neonatal deaths 3.5 per 1,000 births; and maternal deaths 10.3 per 100,000 maternities.

4 Pearson G (Ed) *Why Children Die: a pilot Study 2006*, England (South West, North East and West midlands), Wales and Northern Ireland. 2008.

5 Lewis, G (ed), Centre for Maternal and Child Enquiries (CMACE), *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2006-2008*, 2011.



1.11 However, there is no room for complacency. Successful outcomes in maternity care are linked to the broader public health agenda and require integrated working at local and regional levels. Key interrelated strategic documents recently published or due to be published in 2012 by DHSSPS include:

- *Public Health Strategic Framework (2012-2022)* - due to be consulted upon in 2012;
- *A Fitter Future for All - A Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2012-2022)*;
- *A New Strategic Direction for Alcohol and Drugs (phase 2) (2011-2016)*;
- *Sexual Health Promotion Strategy (2008)* - under revision in 2012 and will incorporate teenage pregnancy;
- *Ten-Year Tobacco Control Strategy* (February 2012);
- *Mental Health and Well-being Promotion* - due for publication in 2012;
- *A Ten-year Breastfeeding Strategy (2012-2022)* - published for public consultation in 2012;
- *Living with Long-Term Conditions - a Policy Framework (2012)*;
- *Tackling Violence at Home (2005-2013)* - with a one-year action plan on domestic and sexual violence to be published mid-2012;
- *Healthy Futures (2010-2015)*;
- *Bamford Action Plan (2009-2011)* - under revision in 2012;
- *Promoting Good Nutrition (2011)*;
- *Regional Hidden Harm Action Plan (2008)*;
- *Healthy Child Healthy Future (2010)*;
- *Co-operating to Safeguard Children (2003)*; and
- *Family Nurse Partnerships programme* - evaluation of pilot is ongoing.

1.12 The cross-Departmental *Bamford Action Plan*⁶ (under revision-to be consulted upon in 2012) recognises the importance of perinatal mental health, the provision of training for staff, development of an integrated care pathway, and detection and treatment of mental illness during pregnancy and the postnatal period. A sub-group on perinatal mental health is currently taking forward these actions.

1.13 In addition, while the majority of perinatal mental health services are located in the community, it is recognised that for a small number of women inpatient mental health services are required. *Transforming Your Care*⁷ supports the development of a regional plan to address the needs of mothers with serious psychiatric conditions.

6 DHSSPS, *Delivering the Bamford Vision - The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability - Action Plan 2009-2011*, 2009.

7 HSC, *Transforming Your Care - A Review of Health and Social Care in Northern Ireland*, 2011.



- 1.14 It must also be acknowledged that reducing health inequalities is not the sole responsibility of DHSSPS and HSC organisations. It requires public engagement and concerted action across local and central government, including District Councils, Department of Education, Department of Employment and Learning, Department for Social Development, Department of Culture, Arts and Leisure, and the Office of the First and Deputy First Ministers, especially in relation to promoting social inclusion. The implementation of the Public Health Framework will provide opportunities for cross departmental working, especially in relation to education and the provision of advice and support for women and girls of childbearing age.

Objective 1

A universal approach to major public health messages for women and girls of childbearing age will be promoted. This includes the importance of healthy life styles, and a focus on the social factors and clinical conditions which are known to have an adverse impact on outcomes for mother and baby.

Summary

- 1.15 This chapter highlights the importance of giving a person the best start in life through promoting and protecting the health and well-being of baby, mother, father, and family members. Some social, emotional and clinical factors have been identified which require concerted regional and local multiagency approaches to improve health outcomes for all and to reduce health inequalities. Investment in early intervention, prevention and support has significant long-term benefits.
- 1.16 The next chapter deals with some of the broader issues which will influence the strategic direction for future maternity care.



Chapter Two - Strategic Context

Introduction

- 2.1 This chapter sets out how DHSSPS policy and strategic direction for maternity care has evolved over the last 20 years, and has been influenced by the reform of the health and social care system with a greater focus on the quality, safety and sustainability of service provision. A modern system must commission high-quality services appropriate to local population needs, taking account of the views of service-users.
- 2.2 The concept of 'promoting normality' during pregnancy and birth is part of the quality and safety agenda as there is evidence that it not only delivers better outcomes, but also improves the experience for mother, baby and wider family circle. Clinical interventions such as caesarean section and assisted delivery are sometimes necessary and can be lifesaving for both baby and mother, but there is a need to ensure that such decisions are based on robust evidence of effectiveness, and taken at senior clinical level in the best interests of the mother and baby. Prospective parents need to be considered as partners in care and given all the information necessary to make informed choices.

Strategic Background to the Review

- 2.3 Recent Northern Ireland policy on maternity services was set out in the policy circular, HSS (SC) 1/96, *The Commissioning and Provision of Maternity Services: Policy Guidelines*⁸. The policy set out the philosophy of care which underpinned maternity services provision, and established policy objectives on Quality of Care, Safety, Choice, Communication, Control, Continuity of Care and Carer, and New Options for Care.
- 2.4 *Developing Better Services*⁹ (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 maternity units¹⁰, recognising that a decreasing birth rate in smaller hospitals may lead to difficulties in maintaining the expert skills required, and make it impossible to sustain the full team necessary to deliver a consultant-led service. DBS also actively promoted the development of midwife-led units¹¹ within or adjacent to consultant-led units.

8 DHSSPS, *Delivering the Bamford Vision - The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability - Action Plan 2009-2011*, 2011.

9 DHSSPS, *Developing Better Services*, June 2002.10

10 Birthplace terms and definitions: Part 2 Nov 2011 pg 12 (See glossary)

11 Birthplace terms and definitions: Part 2 Nov 2011 pg 12 (See glossary)

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Page 21

- 2.5 A DHSSPS Ministerial statement in July 2004¹² created the potential for the development of free-standing community midwife-led units provided that all necessary support systems were in place.
- 2.6 Since the 1990s 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 makes the best use of resources. There is a need to look at how modern maternity services are delivered to women respecting individual choice while ensuring the right care, by the right person, in the right place, at the right time.
- 2.7 The vehicle for major service change is through an evidence-based approach to the commissioning and provision of maternity care. The Health and Social Care Reform Act 2009 set out the key roles and responsibilities of various health and social care bodies. This includes the delegation of service commissioning to the Health and Social Care Board (HSCB) and Public Health Agency (PHA), while DHSSPS retains overriding authority and overall accountability. Local Commissioning Groups (LCGs) are also part of the commissioning process, and have increasing responsibilities for planning and resourcing services for their local populations. Therefore, the HSC commissioners, having engaged at regional and local levels, determine **what** services are best provided taking account of local population needs. HSC Trusts, primary care professionals, and other local providers determine **how** these services are provided. Integrated Care Partnerships, as identified in *Transforming Your Care*, would have an important role in improving the delivery of services.



- 2.8 At policy level, the DHSSPS issues the *Health and Social Care Commissioning Plan Direction (Northern Ireland)*. This is an annual plan by which the Minister sets out his/her vision and strategic priorities as aligned to the Executive's Programme for Government and other cross-Departmental Strategies. The Commissioning Plan Direction drives forward change and informs regional HSCB/PHA and LCGs' annual commissioning plans. Resulting commissioning plans must show that they deliver on the Minister's strategic priorities and statutory obligations. At a high level these are:
- to improve and protect health and well-being and reduce inequalities;
 - to improve the quality of services and outcomes for patients, clients and carers;
 - to develop more innovative, accessible and responsive services, promoting choice and by making services more available in the community;
 - to improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;
 - to improve the design, delivery and evaluation of health and social care through involvement of individuals, communities and the independent sector; and
 - to ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.
- 2.9 In line with the above, the Review of Maternity Services recognised the strategic importance of commissioning to give effect to high-quality service change. The expectation is that this Strategy will be driven forward at both HSC regional and local levels. Further information on how this will be achieved is contained in Chapter Eight, which focuses on how this Strategy will be implemented.
- 2.10 In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, commissioned a review of health and social care provision in Northern Ireland. This was published in December 2011 under the title of *Transforming Your Care*. It contains ninety nine recommendations for change, largely focusing on:
- a person-centred approach to treatment and care;
 - a greater focus on prevention;
 - maintaining care close to home;
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- redesigning primary care; and
- reshaping hospital services (to include a greater focus on hospital networks) thus supporting the principle of Right Care, Right Place, Right Time.

- 2.11 Pivotal to this approach for change is integrated working between hospital and community services, the development of population plans by LCGs based on assessed need, greater use of information technology, further development of workforce skills to support integrated working, and a shift in resources from hospital to community.
- 2.12 More specifically, *Transforming Your Care* made certain recommendations regarding maternity services, including the importance of continuity of care. The full text of these recommendations is contained in Appendix One. These recommendations are complementary to the recommendations in this Strategy - all of which are underpinned by safety and quality.

The Importance of Safety and Quality in Maternity Care

- 2.13 Safety and quality underpins all health and social care services. The focus on safety and quality has several drivers, including the outcomes of local, national and 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 standards and guidelines over the past few years, many of which have been endorsed as best practice by the Department. NICE guidance and regional standards such as DHSSPS Service Frameworks¹³ will lead to more consistent, evidence-based practice.
- 2.14 Learning from Confidential Enquiries into Maternal and Child Health 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 also important indicators of professional best practice. The Regulation Quality and Improvement Authority (RQIA) has carried out important reviews since its establishment, including *The Review of Intrapartum Care*¹⁴ published in 2010. That document highlighted key issues for further development, many of which are being addressed as part of this strategy. 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.

13 Soon to be published Children's and Young People's Service Framework. Also *Healthy Child, Healthy Future and Long-Term Conditions Framework*.

14 RQIA, Report on the RQIA Review of Intrapartum Care, March 2011.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Page 24

- 2.15 The Department's ten-year *Quality 2020 Strategy*¹⁵ identifies quality under three 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; and
 - **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.
- 2.16 Evidence shows that a focus on promoting normality in birth results in better quality, safer care and an improved experience for mothers, fathers/partners and their babies¹⁶. Pregnancy and childbirth is not without risk, and appropriate interventions can and do save the lives of mothers and babies.
- 2.17 There is a need to promote normality in pregnancy and childbirth in order to secure the future health and well-being of women and their families. 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 Ireland. In the absence of persuasive evidence to support such high intervention rates, maternity units should be working to make their intervention rates comparable to those of the rest of the UK.

¹⁵ DHSSPS, *Quality 2020: A Ten-Year Quality Strategy for Health and Social Care in Northern Ireland*, November 2011.

¹⁶ NHS Institute for Innovation and Improvement, *Promoting Normal Birth*, 2010.



Births by Method of Delivery in 2010/11 by Country

Country	Births	% Normal Deliveries	% Assisted Deliveries	% Caesarean Section	% Unknown Deliveries
Northern Ireland ¹	25,915	56.2%	13.5%	29.9%	0.3%
England	668,195	62.2%	12.9%	24.8%	2.1%
Wales	32,649	61.0%	12.5%	26.0%	1.9%
Scotland ²	56,185	61.7%	12.9%	25.4%	0.0%
Ireland ²	74,278	61.0%	14.0%	25.0%	0.0%

Sources: Northern Ireland - Child Health System; England - HES Online, Health and Social Care Information Centre; Scotland - SMR02, ISD Scotland; Wales - Statswales, Welsh Assembly Government; Ireland - www.bump2babe.ie

Notes

- 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.
- Figures shown for Scotland and Ireland are for 2009/10 as information is not yet available for 2010/11.

The Need for Sustainable Maternity Services

- 2.18 To ensure that maternity services meet quality standards and provide high-value, evidence-based care at all times, there is a need to review how and where services are provided. Maternity policy must focus on as much care as possible being delivered close to home, but at the same time recognise that if more specialist care is needed this should be provided within a unit that meets NICE recommendations¹⁷.
- 2.19 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 neonatology/paediatrics. The focus on population-planning, based on assessed need, will ensure a balance between local and specialist care provision.



Objective 2

A culture of 'normalisation' of pregnancy and birth will be promoted as part of population planning and the commissioning and provision of maternity care. The principles outlined in *Transforming Your Care* will inform how access to maternity services and maternity care is best promoted and provided.

The Views of Women

- 2.20 The views of women are important in the planning, commissioning, delivery and evaluation of maternity care. To some extent, women's views are shaped by the pattern of maternity service provision either they have had in the past, or family or friends have experienced. Trusts must ensure they engage with women which can effectively be conducted through the Maternity Services Liaison Committees.
- 2.21 As part of the development of this maternity strategy, the Patient and Client Council¹⁸ co-ordinated user engagement. When asked to identify priorities for improvement, service 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 were other areas suggested for improvement. Women also wanted the choice of seeing an obstetrician during their pregnancy, have shorter waiting times at clinics, and be provided with more practical support with breastfeeding. It was suggested that development of antenatal education should be more responsive to societal changes, and the importance of bereavement training for staff was also raised.
- 2.22 The views of service-users are essential in the delivery of maternity services and the Project Board welcomed their comments. It is clear that a responsibility exists to ensure that women are well-informed about services, and the roles of professionals who provide care. Clearly, if there is a lack of information about the role a midwife has in the care of women during pregnancy and birth, a woman may then expect to see a consultant at some point in her pregnancy.



- 2.23 Prospective parents 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 parent's needs. All information should also be accessible to them, with due consideration given to additional needs such as physical, sensory or learning disabilities or inability to speak or read English as a first language. Every opportunity should be taken to provide the parents or other relevant family members with the information and support they need (for example, the provision of *The Pregnancy Book*¹⁹ in an appropriate format). The Maternity Hand Held Record also provides an opportunity for women to be 'partners in maternity care', and to inform parents and share information.

Objective 3

Prospective parents should be considered as partners in maternity care and given all relevant information, in appropriate formats, to make informed choices about what is best for them and their baby.

Summary

- 2.24 Health and social care services continue to evolve, as do maternity care and services. Safety, quality and sustainability of service provision are essential to deliver the best outcomes for mother, baby and family. The promotion of 'normalising' pregnancy and birth is part of the quality and safety agenda. For those women who require specialist interventions, these should be based on evidence of effectiveness and undertaken by skilled professionals in an appropriate clinical environment. HSC commissioners of maternity care have a major role in critically appraising where services are best provided, taking account of population needs. Prospective parents need to be considered as partners in care and given the information to make informed clinically appropriate choices about maternity care.
- 2.25 The next chapter sets out roles and responsibilities in maternity services and care, and highlights how partnership-working, good clinical leadership, and communication are fundamental to support women, their partners and family.



Chapter Three – Driving Change Through Clinical Leadership, Workforce Development and Effective Communication

Outcome: Effective communication and high-quality maternity care.

Introduction

- 3.1 This chapter sets out the roles and responsibilities in maternity care, recognising the importance of the interface between community and hospital services when delivering care to the mother, her baby, partner and the wider family. It highlights that maternity services are delivered by teams of clinicians (such as midwives, obstetricians, anaesthetists, neonatologists and paediatricians) who are experts in delivering maternity services. However, maternity care has a broader focus; it not only includes maternity clinicians but also others such as GPs, health visitors, pharmacists, allied health professionals (for example, physiotherapists and dieticians), dentists and ambulance service personnel. A change in culture is required by all relevant healthcare professionals and managers to “normalise” birth.
- 3.2 It highlights that to have successful maternity care requires:
- effective clinical leadership and clear communication pathways between all involved in maternity care;
 - a skilled workforce which understands specific roles and responsibilities;
 - a sustainable configuration of service provision;
 - a focus on improving clinical outcomes supported by data collection and analysis of quality indicators; and
 - appropriate Information Communication Technology (ICT) support which continues to develop to meet regional and local needs.
- 3.3 Maternity services do not exist in isolation of other services, and it is important that interfaces between services are recognised and that partnerships between services are enhanced.
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MATERNITY TEAMS

Midwives

- 3.4 Midwives are expert practitioners in the provision of care to women with straightforward pregnancies. The Project Board during the review fully endorsed the key messages set out in *Midwifery 2020*²⁰, which is a vital UK-wide programme setting 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 *Midwifery 2020* is that all care for the majority of women with straightforward pregnancies will be provided by a midwife.
- 3.5 *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 there is a need to ensure the service makes maximum use of their skills as a unique resource to ensure the best care for women. Commissioners and providers must ensure that midwives take responsibility for caring for women with straightforward pregnancies as well as coordinating care for high risk women in order to utilise their skills in the delivery of high-quality maternity services.
- 3.6 As the reconfiguration of maternity services evolves and transforms, it is essential for midwifery that strong leadership, effective communication, and support are promoted and developed as fundamental elements. This will be supported by the midwifery supervision framework²¹. Statutory supervision of midwives protects the public by promoting best practice and preventing poor practice.
- 3.7 The Local Supervising Authority Midwifery Officer (LSAMO), along with each of the Trust's supervisors of midwives, midwifery management and consultant midwives, have a pivotal leadership role in the promotion of the skills of the midwife, normalising birth, reduction of intervention rates, and ensuring models of care, including midwife-led units and home births, are safe, sustainable and family-centred.

²⁰ *Midwifery 2020 Programme, Midwifery 2020: Delivering Expectations*, 2010.

²¹ Nursing and Midwifery Council (NMC), *Supervision, support and safety - NMC quality assurance of the LSAs 2010-2011*, 2011.



Consultant Midwives

- 3.8 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 commissioning and addressing public health issues.

Maternity Support Workers

- 3.9 *Midwifery 2020* also recognises the valuable input maternity support workers (MSWs) have made to the maternity team. Although they will not replace midwives, maternity support workers will 'assist' members of the maternity team and undertake roles appropriate to their training. The use of maternity support workers can be of immense value by ensuring more effective use of midwives' time. It will, therefore, be vital for clearly defined roles, responsibilities and arrangements for delegation and supervision to be agreed to enable the service to make best use of these staff, as well as providing a satisfying career choice for them. Careful attention should be paid to ensuring that the overall ratio of midwives to maternity support workers meets the recommendations of Birthrate Plus²², the most widely recognised workforce planning tool for midwifery services.

Consultant obstetricians

- 3.10 Over time the role of the obstetrician has changed, with increasing consultant presence now on the labour ward. Obstetricians spend more of their time dealing with those women and babies presenting with higher risks (from clinical, emotional and social factors, as well as more complex intrapartum and postnatal care). The consultant's 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 leading and participation in multi-disciplinary teams. They will also often have significant management or professional leadership roles. Their leadership is a significant element of the necessary culture change that is required to normalise birth.



Training for Junior Doctors

- 3.11 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 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.
- 3.12 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 HSC staff since 1998, they have only applied to doctors in training since 2009. Most maternity units now provide arrangements that comply with 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, there is a need to ensure that the service has a workforce fit for purpose and adequate to meet demands.

Other Related Specialisms

- 3.13 Other services which interface with maternity services include paediatric/neonatal, anaesthetic, gynaecology and specialist mental health services. The importance of perinatal mental health has already been considered in Chapter One. While all of these specialist services are not considered as part of this Strategy it is important that good links are forged between the services to ensure the best quality care for women throughout pregnancy and following birth. A neonatal network is being established (2012) which will provide further opportunities to collaborate.
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Paediatric/neonatal services

- 3.14 Although midwives and obstetricians have skills in resuscitation and stabilisation of babies, consultant-led units where babies with additional care needs, including prematurity, will be born will need additional neonatal provision. This will often be provided as part of the paediatric service, with the same medical and nursing staff providing neonatal and paediatric medical care. Any service changes considered will, therefore, need to be assessed according to their impact on both neonatal and paediatric services.

Anaesthetic services

- 3.15 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.

Gynaecological services

- 3.16 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.

The Role of Primary Care Practitioners

- 3.17 An estimated 20,000 people access GP practices in Northern Ireland every day²³ and it is estimated that over 91% of people access community pharmacies every month²⁴. Satisfaction rates are high. Each has their own expertise, such as the pharmacist in medicines advice in pregnancy and medicines management.
- 3.18 The GP practice is well placed to know the individual patient and their family, very often having provided care to several generations of the same family. For example, they know the general lifestyle of the woman (possibly in childhood, teenage years and though to adulthood) and may

23 Northern Ireland Statistics and Research Agency, *Continuous Household Survey & Mid-Year Estimate 2008/09*.

24 DHSSPS, *Community Pharmacy Activity Survey* (Pricewaterhouse Coopers), 2000.



be managing certain chronic clinical conditions (for example, diabetes, epilepsy, high blood pressure) which could have a significant impact on any future pregnancy. Chapter One highlights the interrelationship between lifestyle, clinical and social factors and their potential to increase risk and adverse outcomes in pregnancy.

3.19 While acknowledging that the role of the GP in maternity care has changed considerably since the introduction of the current GP contract in 2004, GP practices have a privileged place in delivering general care to all their patients including pregnant women. It is, therefore, essential that GP practices use every opportunity to work as part of the maternity team in the interests of the individual woman, for example:

- **Preconceptual care** - providing opportunistic advice as part of implementation and review of disease registers.
- **Antenatal care** - sharing information with the lead clinicians either midwife or obstetrician or consultant physician (when clinical complexities coexist) on lifestyle, clinical and social factors which might have an adverse impact on the pregnancy and outcome, for example, previous medical history, substance abuse, sexual health, nutrition, current clinical management of long-term conditions, and social factors such as unemployment, poor housing, or domestic violence. In addition, there is strong evidence that those with previous mental health conditions need to be adequately supported throughout their pregnancy. GP practices will also have a pivotal advice and support role in the event of a miscarriage.
- **Postnatal care** - assessing the cause and management of common conditions such as back pain, mental health issues, urinary symptoms and incontinence, and sexual dysfunction, in addition to providing important advice on sexual health and contraception.

3.20 Information-sharing and communication are key to the successful partnership working of the maternity team, particularly at the interface between primary, community and secondary care. It is a two-way process that requires not just GP practices to be part of that team-based approach, but also that midwives and obstetricians keep GPs informed of progress, investigations and test results of all pregnant women registered in the GP practice.





Objective 4

A maternity communication protocol/pathway will be developed outlining the principles for communication and information sharing across the primary, community and hospital interface. As part of this process, each should understand respective roles and responsibilities especially on 'who' and 'how' a pregnant woman contacts the health service in the event of a concern or clinical emergency.

Role of Voluntary and Third Sector Organisations

- 3.21 There are a number of voluntary and third sector supporting networks throughout Northern Ireland, such as SureStart and National Childbirth Trust (NCT), which will play an important role in the future delivery of maternity services. It is, therefore, important that the commissioners and providers of maternity services engage meaningfully not only directly with women and their families, but also through these networks. It is envisaged that the development of Integrated Care Partnerships, as outlined in *Transforming Your Care*, will provide a real opportunity for providers to work together. HSC organisations should work with relevant voluntary providers to standardise information and the support given, so that messages are consistent across the region, regardless of where women and partners access services.
- 3.22 HSC Trusts are encouraged to build partnerships with the voluntary and third sector to strengthen preconceptual public health messages, which will continue through pregnancy to the postnatal period.

Role of Ambulance Services

- 3.23 Whilst the majority of women never have need of an ambulance during their pregnancy, nonetheless, ambulance services play a vital role in the event of an emergency. For example, they play a vital role in the safe transfer of women between units. When complications arise in pregnancy, such as a very early labour, fetal distress, haemorrhage or a prolapsed cord, the Northern Ireland Ambulance Service (NIAS) has a pivotal role in the emergency transfer of the women from a midwifery led unit to a consultant-led obstetric unit. Trusts must engage with NIAS to develop clear protocols for requesting and performing transfers either between different units within the Trust or between Trusts, or from home. 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

- 3.24 A small number of women in Northern Ireland have private obstetric care, but there is no private maternity hospital here. In addition, certain obstetric units close to the border with the Republic of Ireland also provide private care for women from that jurisdiction. Some women resident in Northern Ireland 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 (see paragraph 3.35).

Clinical Leadership and Communication

- 3.25 Good clinical leadership, workforce development and use of technology are essential for a high-quality, sustainable maternity service in Northern Ireland. Clinical leadership is essential for quality improvement and innovation in maternity care. Clinicians must be experts in their own field, as well as competent clinical leaders and managers. As team members, they must also know and understand other members' responsibilities.
- 3.26 The importance of good communication at the interface between primary, community and secondary care has already been highlighted. However, high-quality maternity care also depends on good communication between all staff such as midwives, obstetricians and anaesthetists, particularly when urgent transfers are required.
- 3.27 There are a number of areas where multi-professional communication is already evident, such as through the Trusts' Labour Ward Forums; this promotes multi-professional communication within Trusts, and the monitoring of serious incidents to learn and change practice as a result. Nonetheless, communication between medical and midwifery staff is variable across Northern Ireland. Steps to expand multidisciplinary
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collaborative working could yield significant improvements in provision of care.

- 3.28 Northern Ireland uses a regional hand-held maternity record which is available for every woman. The template for this record is reviewed yearly to ensure it is fit for purpose. In addition, an operating protocol is being developed which will further highlight and enhance security and other data protection commitments. The maternity hand-held record (MHHR) includes information based on NICE guidance for the woman as well as healthcare professionals. It is designed to be used by all professionals, including GPs, 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 by the community midwifery team at the end of her postnatal care, there are some logistical issues which currently prevent this from happening consistently throughout Northern Ireland. This situation is currently under review.
- 3.29 While all units have now introduced the maternity hand-held record, thereby making co-ordinated regional development of its use easier in the future, all HSC Trusts need to comply with the operating protocol when it becomes available.

Objective 5

Maternity services must show good clinical leadership and communication, including in the use of the maternity hand-held record, Labour Ward Forum and other multidisciplinary groups.

Workforce Training and Development

Midwifery Workforce

- 3.30 Provided that the workforce balance is correct as outlined by Birthrate Plus²⁵, women with straightforward pregnancies can be appropriately managed throughout their pregnancy by midwives as the lead professional. This does not necessarily mean that in order to deliver this choice there needs to be an increase in the number of midwives employed. Instead, it essentially means a change in how and where midwives are working.



3.31 Evidence has demonstrated that providing more midwife-led units and more home births can result in fewer interventions. In addition, there has been a very successful cohort of maternity support workers (MSWs) who have been adequately trained to undertake many of the tasks traditionally carried out by midwives. It has been agreed that training for maternity support workers will be funded and commissioned. Therefore, with a well-balanced, blended skill-mix of midwives and appropriately trained MSWs, women with straightforward pregnancies can be appropriately managed throughout their pregnancy by midwives as the lead professionals.

3.32 Currently, Birthrate Plus is the workforce planning tool of choice for assessing midwifery staffing establishments within Northern Ireland as it includes important factors for calculating one-to-one midwife care in labour and the categorisation of types of care provided to women, as well as taking into account antenatal and postnatal requirements. It is recommended that commissioners ensure providers carry out a review of their current service provision, including care in the community, in order to reconfigure the way in which midwifery care is currently delivered. This must be completed by conducting a workforce planning and skills set analysis in preparation for the future of how midwifery care is delivered.

Medical Workforce

3.33 Changes in medical training programmes, combined with the impact of the European Working Time Directive, mean that all services are moving to more direct medical care being provided by consultants and other career grade staff. Doctors in training will continue to provide an important element of service provision, but some of the more routine work, which contributes less to their training, can appropriately be taken over by other members of a multidisciplinary team.

3.34 Within obstetrics and gynaecology some doctors will develop sub-specialty interests. Most will continue to provide general obstetric and gynaecological services in addition to any sub-specialisation. Each team of doctors needs to ensure doctors have a workload that maintains and develops their skills within job plans that are sustainable, by conducting skills analysis and workforce planning.





A Focus on Quality Improvement and Measurement

- 3.35 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 monitor changes in their own practices over time, and to benchmark their practices 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 Forum²⁶ which supports Trusts in their drive to provide safe, quality care. Through the multi-professional and regional work of this forum, communication and learning between professions and Trusts have been enhanced; it is important that this continues.
- 3.36 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 must continue to take full account of the findings and recommendations from confidential enquiries in the commissioning and provision of services.

Objective 6

Work will 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

- 3.37 The NIMAT system allows recording of a large amount of detail about the woman's past medical, social and obstetric history, and her current pregnancy. However, the system must be improved, including its ability to share data with other health service IT systems. Where data-sharing occurs, it must be underpinned by data-sharing agreement protocols, as part of information governance within health service organisations. Improvement in electronic support is essential; for example, in the ease of information entry, ability to access the system in community settings, communication with other health information systems and in the retrieval of unit level



data to support audit and service improvement. Now that all units have introduced the NIMAT system, co-ordinated regional improvement to the system must be undertaken without delay. Any improvement will need to take account of data protection principles and the new Data Sharing Code of Practice²⁷.

Objective 7

The NIMAT system will be continually reviewed and updated to ensure it is 'fit for purpose' to promote coordinated regional data collection, in line with data protection principles and information governance.

Summary

- 3.38 Women need to be seen as partners in maternity care. High-quality care requires continuity and communication across primary, community and secondary sectors with each professional understanding respective roles and responsibilities. The role of the voluntary sector in the support of parents is acknowledged. Effective communication pathways must be put in place. Clinical leadership will drive change in maternity care and will be supported by a regional approach to quality improvement, supported by an ongoing commitment to ICT and connected health.
- 3.39 The next four chapters consider how all aspects of maternity care are delivered - preconceptual, antenatal, intrapartum and postnatal to ensure that high-quality sustainable services continue to be available and accessible to women in Northern Ireland.



Chapter Four – Preconception Care

Outcome: Healthier women at the start of pregnancy (Preconception care)

Introduction

- 4.1. The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood, starting in the womb, and having lifelong effects on many aspects of health and well-being from obesity, heart disease, mental health, to educational achievement and economic status. Preconception care is any advice or management that occurs before a pregnancy. Chapter One highlights the interrelationship between social factors, lifestyle, and emotional and clinical conditions on the health of parents, new baby and wider family. There is robust evidence 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 socio-economic area or who were 'looked after' as children or are currently being 'looked after'²⁸.

Provision of preconceptual advice and support

- 4.2 The major areas where prospective parents need advice, information and support prior to pregnancy are:
- **A healthy lifestyle** - for example, a balanced diet, including the importance of Vitamin D, physical activity, help to stop smoking, minimising intake of alcohol, and stopping recreational drugs;
 - **Weight management** - getting as close to a healthy weight as possible;
 - **Folic Acid** - to reduce the risk of neural tube defects (such as spina bifida);
 - **Rubella immunity** - to reduce the risk of rubella infection, especially in the first eight to ten weeks of pregnancy;



- **Sexual health** - especially to identify the risk of infection and, where identified, to take appropriate action (for example, in hepatitis B, HIV and other transmitted infections);
- **Pre-existing familial conditions** - so that parents can receive appropriate genetic counselling, screening and support if needed;
- **Pre-existing clinical conditions** - especially those where medication is being prescribed as part of management (for example, diabetes, epilepsy, high blood pressure, and mental health conditions), and the need to access specialist maternity services early in pregnancy;
- **Previous poor obstetric history** - so that early access to maternity care can be arranged to improve outcomes;
- **Social care support** - identification and support for those with complex social factors, including vulnerable parents, children in need and those at heightened risk of domestic violence; and
- **Access to maternity care** - how to access care and the importance of presenting early in pregnancy, regardless of previous clinical history or social circumstances.

4.3 Currently in Northern Ireland preconception care, including lifestyle choices, and advice on starting folic acid if planning a pregnancy is generally provided by family-planning clinics or GPs, 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.

4.4 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 folic acid supplements. Women with diabetes (Type 1 or 2) need to take high-dose folic acid which is only available on prescription.

Long-term conditions, such as diabetes, high blood pressure, depression and others

- 4.5 It is appropriate that there is a multiagency approach to the provision of universal and opportunistic preconceptual advice, information and support. However, for those parents with known conditions requiring specialist advice and support, more must be done. Preconception counselling for women with existing clinical conditions was the number one recommendation in the CEMACH 2007 report²⁹.
- 4.6 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, high blood pressure, diabetes, heart problems, epilepsy, depression and others. 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. Community pharmacists have particular expertise on advising on medications in pregnancy.
- 4.7 The rising numbers of women with long-term conditions who may consider having a baby means that increasingly specialists and primary care professionals, like 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 NICE³⁰ on mental health, diabetes and hypertension all include pre conception advice. GP practices, as part of the 2004 GP contract, have disease registers which could provide relevant information to assist in the identification of patients who might benefit from preconceptual care. Every effort should be made, at local level, to use this information in an appropriate way and incorporate it into the planning and delivery of a maternity care pathway for such women and their partners.

29 CEMACH, *Diabetes in pregnancy: are we providing the best care?*, 2007.

30 NICE Clinical Guidelines, *Antenatal and Postnatal Mental Health* (CG45), *Diabetes in pregnancy* (CG63), *Hypertension in pregnancy* (CG107).



Objective 8

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 will be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management.

Objective 9

A clear pathway of care will be available for individuals with long-term conditions who are planning a pregnancy and throughout the pregnancy.

Unplanned pregnancy

- 4.8 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. It is known that not all pregnancies are actively planned; a recent CEMACH report³¹ indicated that only around half of pregnancies are 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 PHA provides information leaflets on important issues such as folic acid intake. There have also been formal publicity campaigns about folic acid in the past, but none in recent years. The PHA should consider how best to inform women of the importance of folic acid in pregnancy.
- 4.9 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 weight³² and limiting alcohol will reduce the likelihood of pregnancy problems for mothers and babies, but are also the advice given to the general population. NICE³³ guidelines on stopping smoking and weight management include specific pre conception advice.
- 4.10 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

31 CEMACH, *Diabetes in pregnancy: are we providing the best care?*, 2007.

32 CMACE, *Maternal Obesity in the UK; findings from a national project* (2010)

33 NICE, *Quitting smoking in pregnancy and following childbirth* Public Health Guidance PH26, June 2010, and *Weight Management Before, During and After Pregnancy*, Public Health Guidance PH, 27 July 2010.



professionals involved in the postnatal period to recognise that this is also the preconception period for future pregnancies.

Summary

- 4.11 Parents who are fit and healthy at the beginning of pregnancy generally have healthier babies. Some pregnancies are planned, many are not. A range of information and support needs to be available for all parents and a targeted approach to preconceptual care made for those at greater risk of poor pregnancy outcomes, including those with long-term clinical conditions and those at greater risk either through age, social factors and/or ethnicity. Further work is required by the Public Health Agency and health and social care professionals, including GPs and specialists, to maximise the benefit of preconceptual advice, information and support for parents.





Chapter Five – Antenatal Care

Outcome: Effective, locally accessible, antenatal care and a positive experience for prospective parents

Introduction

- 5.1 This chapter outlines current custom and practice in the delivery of antenatal care and how such services need to adapt and change to meet the needs of prospective parents and families. Most antenatal care should be delivered in the community as close as possible to the family home; the exception being for those women who, because of their health, emotional well-being, and/or social circumstances need to access more specialist services which may be best provided in a larger centre. As with all aspects of the maternity pathway, two way communication and partnership working are fundamental components of success. Every effort should be made to provide comprehensive antenatal education in easy to access formats and settings, taking account of the needs of hard to reach groups.

Definition of Antenatal Services

- 5.2 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 Maternity Assessment Unit or as an inpatient in hospital (see paragraphs 5.15 - 5.17). 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 the 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. There is a 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

- 5.3 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 (including the dose of folic acid, if she has either Type 1 or Type 2 diabetes), lifestyle choices and options for maternity care. As identified in Chapter One, of particular note is the need for discussion on substance abuse including cigarette cessation, sexual health, nutrition, medical history, current clinical management of long-term conditions, and social factors such as unemployment, poor housing, or domestic violence. Such discussion will assist in risk assessment and early specialist referral, if required.
- 5.4 In addition, antenatal screening and the prevention and control of infectious diseases in pregnancy are important in protecting the health of mothers and babies. The DHSSPS issues guidance on infection control in pregnancy based on evidence and recommendations from a number of national bodies, including the National Screening Committee, NICE, the Joint Committee on Vaccination and Immunisation, and CMACE reports.
- 5.5 There is a tendency to rely on women to present themselves to their GP when they become pregnant, but more can be done 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, who often are the very women who would benefit most from earlier booking. Direct access to midwives as the first point of contact in the community is intended to increase the number of women making early contact with maternity services.

Objective 10

When a woman becomes pregnant she will be facilitated to make early direct contact with a midwife.



Booking Visit

- 5.6 This visit is usually the woman's first contact with maternity services. Its purpose is to confirm pregnancy by ultrasound scan, take a full medical and social history from the woman to assess her needs, and carry out antenatal screening tests. In all Trusts women are 'booked' on the Northern Ireland Maternity (NIMAT) system, a computerised recording system. However, how and where this 'booking' takes place varies between Trusts. In some Trusts, women must go to the hospital, while others attend in the community and are then referred to the hospital for the booking scan³⁴. 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.
- 5.7 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, obstetric and social 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.
- 5.8 In future, the midwife will arrange the booking visit which, for the majority of women, will take place in a health and care centre or GP surgery. Bookings may also be undertaken at midwife led maternity units or non acute hospital sites. Midwives will carry out booking and 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 the NIMAT system. Normally, 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.

Objective 11

There will be appropriate access to booking scans and the NIMAT system in community and non-acute hospital settings.



Antenatal Visits

- 5.9 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 by obstetricians and midwives; and
 - private obstetric care by an obstetrician.
- 5.10 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. In some areas 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. It is known from recent surveys that women indicated that travel to hospital and long waits at hospital clinics were negative experiences during their pregnancy.
- 5.11 For healthy women without complications there is no persuasive evidence that they require the attention of an obstetrician³⁵. As highlighted earlier, women's expectations are shaped to a certain extent by the pattern of maternity services they or other family members have experienced. While midwifery-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 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.



- 5.12 There is a 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 when 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.

Objective 12

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

- 5.13 The antenatal care pathway for women with straightforward pregnancies should be based on the NICE antenatal care guidelines. Antenatal care should ensure early and continuous assessment of physical, mental and social risk factors and referral to specialist services if appropriate. Discussions regarding the model of care/place of birth based on mother's choice plus on-going assessment of need are also appropriate as antenatal care progresses. Midwives will also provide information and advice about healthy living and discuss breastfeeding during the antenatal period. At every antenatal visit the midwife will carry out a risk assessment to assess the appropriate antenatal care. Where risk assessment identifies that a woman requires additional physical, obstetric, 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)³⁶.
- 5.14 Where care is transferred from the midwife to a consultant, or vice versa, it is important that this is documented, so that in any point in a pregnancy it is clear as to who the lead professional is for her maternity care. 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. Recent Confidential Enquires have shown that the most common cause for maternal deaths is now indirect causes such as cardiac or neurological conditions. Maternity services should develop agreed integrated care pathways for



women with complex pregnancies. The pathway should start from the time the complication is identified, which may be at the preconception stage for underlying conditions, or at any time during the pregnancy. There should be clear protocols for rapid referral between midwives, obstetricians and physicians, and the GP must be kept informed. The pathways should ensure evidence-based care that is co-ordinated across all the relevant professionals.

Objective 13

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

Early pregnancy clinics

- 5.15 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.

Maternity Assessment Units

- 5.16 Maternity Assessment 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, the units can be inappropriately used, which has led to increased activity in these units and putting undue pressure on other aspects of maternity services.
- 5.17 While it is important that those women who require the services of a Maternity Assessment 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 maternity assessment unit, to which midwives as well as GPs



and obstetricians will be able to refer women for further assessment or management.

Objective 14

Women will 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 Maternity Assessment Unit.

- 5.18 A small number of women with complex problems will continue to need inpatient care at some point in their pregnancy and every consultant-led unit should continue to provide this service.

Antenatal Education

- 5.19 Currently all maternity services provide antenatal information 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. It is of note that attendance is particularly low among women who have previously had a baby.
- 5.20 Good antenatal education is vital to ensure that there is a reduction in the gap in health inequalities and to prepare women and their partners for parenthood. Uptake of antenatal education in Northern Ireland is variable, although there is an acknowledgement that the HSC does not always provide classes appropriate to the needs of women and their families. There is a need to ensure antenatal education is targeted at those who will benefit most, and that education classes are provided in partnership with the woman and the various professions and agencies. Antenatal education also needs to be updated to include more about coping in early parenthood, promoting breastfeeding and the importance of parent-child interaction for infant brain development.
- 5.21 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 two years of age. The programme goals are to improve antenatal health, child development, and parents' economic self-sufficiency.
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Evidence from other countries supports the targeting of education, using a range of models, to meet the specific needs of women and their families.

- 5.22 There is a need to look at more innovative ways of ensuring women and their families receive the evidence-based information and education they require. This could include the use of new technologies and social media.

Objective 15

Antenatal education will be enhanced and active involvement of prospective parents will be encouraged; this education will primarily 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 for birth.

Summary

- 5.23 Early access to advice, information and appropriate support are vital components of good antenatal care. Most antenatal care should be delivered in a location which meets local needs. Risk assessment should be continuous throughout the antenatal period. Those women with straightforward pregnancies will have a midwife as the lead maternity specialist. For those with a higher risk, the consultant obstetrician will be the lead maternity specialist. Regardless of which professional leads, a team-based approach to care should be undertaken with direct involvement of prospective parents.
- 5.24 The next chapter outlines intrapartum care and where it is currently located in Northern Ireland. It sets out the strategic direction for change, highlighting the need to take account of the principles set out in *Transforming Your Care*.
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Chapter Six – Intrapartum Care

Outcome: Safe labour and birth (intrapartum) care with improved experiences for mothers and babies.

Introduction

- 6.1 Intrapartum care is the care and support for a woman (and her partner) in labour.
- 6.2 This chapter highlights the current configuration of services, and the difference between midwifery-led and consultant-led care. Service configuration will change in line with evidence-based practice and the recognition of the interdependency of specialist maternity services and other key clinical services. The principle of local population-planning is outlined in *Transforming Your Care*, which also proposes a shift towards the community and a remodelling of major acute services with the formation of number of acute hospital networks. This, over time, will change services to a greater emphasis on appropriate care, such as midwife-led units for women with straightforward pregnancies, with more specialist maternity services provided in larger centres.
- 6.3 Just over 55% of births in Northern Ireland are normal vaginal deliveries. There is unexplained variation in intervention rates (such as caesarean section) when compared to other regions in the UK and Ireland. A culture of normalisation of birth has the potential to reduce unnecessary interventions and to improve the birthing experience for the parents, baby and family.
- 6.4 Most women have good pregnancy outcomes and positive experiences but, sometimes, tragedies do happen. The importance of advice, information and support through the bereavement period is recognised.

Current Configuration of Maternity Services

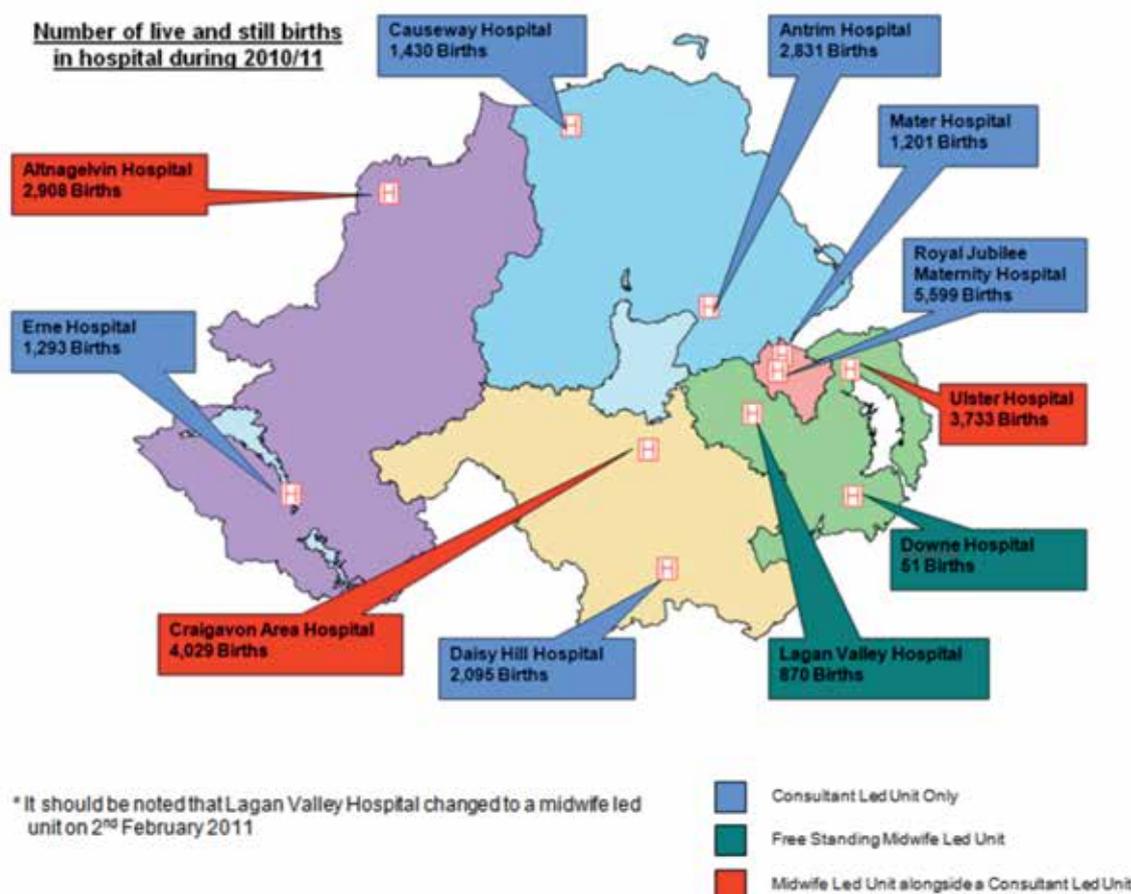
- 6.5 In Northern Ireland in 2010 over 90% of women gave birth in a consultant-led unit, with less than 10% in a midwife-led unit and less than 1% at home. There are currently nine consultant-led units - Altnagelvin, Antrim, Causeway, Craigavon, Daisy Hill, Erne, Mater, Royal Jubilee and Ulster

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Hospital - providing a range of options for birth from no interventions at all to births with epidurals, instrumentally assisted and caesarean section deliveries.

6.6 There are five midwife-led units, three of which are adjacent to obstetric-led units (Altnagelvin, Craigavon and the Ulster Hospitals). There are two freestanding midwife-led units (Downe from March 2010 and Lagan Valley from February 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. The map below shows the location and number of births in each hospital in 2010/11.





Choice of place of birth

- 6.7 Although the choice of place of birth has increased in recent years there are still variations in choice depending on where one lives. 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. There is a need to consider how this can be addressed.
- 6.8 To date Northern Ireland has lagged behind in the development of midwife-led units. These 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 Care* guidance³⁷ advises that women considering giving birth in a midwife led unit should be told they are less likely to have an intervention. However, if complications arise, these women will need to be transferred to a consultant-led unit.
- 6.9 While the evidence about the benefits of different planned places of birth is limited, it is known that for pregnancies assessed as straightforward there are benefits in giving birth in midwife-led units.³⁸ The Birthplace cohort study³⁹ looked at almost 65,000 low-risk women in England in 2008-10, and found that for straightforward pregnancies, giving birth is generally very safe in terms of adverse perinatal outcomes. For example, stillbirth in labour, early neonatal death or specified birth related injuries were low (4.3 events per 1,000 populations). Midwife-led units appear to be safe for the baby and offer benefits to the mother. It found that for women who chose to give birth in midwifery-led units there were no significant differences in adverse outcomes compared with planned birth in an obstetric unit, but midwifery-led units had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit. Transfers from a midwife-led unit during or soon after labour was about one in every ten women having their second or subsequent baby, and around four in every ten women having their first baby. The key findings of the Birthplace study on straightforward pregnancies are:
- giving birth is generally very safe;
 - midwifery units appear to be safe for the baby and offer benefits for the mother;

37 NICE Clinical Guideline (CG55), *Intrapartum Care*, 2007.

38 Sandall, J et al., *Midwife-led versus other models of care for childbearing women (Review)*, published in *The Cochrane Library*, 2009.

39 Birthplace in England Collaborative Group, *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study*, November 2011.



- for women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother;
- for women having a first baby, a planned home birth increases the risk for the baby;
- for women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after birth; and
- for women having a second or subsequent baby, the transfer rate is around 10%.

6.10 In a research paper related to the Birthplace cohort study published in 2011⁴⁰, the cost-effectiveness of alternative planned places of birth in women with straightforward pregnancies, at low risk of complications, was evaluated. The study acknowledges some limitations, but it does support the policy of choice of planned place of birth for straightforward pregnancies. The key findings from this piece of research are:

- planned birth at home, in a freestanding midwifery-led unit, or in an alongside unit generates incremental costs savings compared with planned birth in an obstetric unit;
- for nulliparous⁴¹, low-risk women, planned birth at home generates incremental cost savings but increases adverse perinatal outcomes;
- for multiparous⁴², low-risk women, planned birth at home generates incremental cost savings with no significant effect of adverse perinatal outcomes; and
- for maternal outcomes, planned birth at home was the most cost-effective option.

6.11 A recently published study from Denmark⁴³ highlighted that for straightforward pregnancies there was no difference in perinatal morbidity or mortality in infants between the births in a freestanding maternity unit and those who give birth in an obstetric unit. The freestanding units in this study were located in community hospitals capable of life supporting assistance in the event of an emergency, i.e. the hospitals had an intensive care unit but no obstetric services.

6.12 In addition, as outlined in the Danish study, for women the benefits of giving birth in a midwife-led unit were acknowledged such as less maternal morbidity and less birth interventions including caesarean section, when compared to an obstetric-led unit. However, an awareness of the potential

40 Birthplace in England Collaborative Group, *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study*, November 2011.

41 Nulliparous – a woman who has not previously given birth to a baby.

42 Multiparous – a woman who has previously given birth at least once.

43 Overgaard, Møller, Fenger-Grøn, Knudsen, Sandall, *Freestanding midwifery unit versus obstetric unit: a matched cohort study of outcomes in low-risk women*, 2011.



need for transfer is important when developing these services. As this study shows, 37% of primigravida (i.e. first baby) and 7% of multiparous women (one or more previous births) transferred to an obstetric unit during or less than two hours after birth. Caution must be used in the transferability of studies from one environment to another. However, this study does highlight the need for prospective parents to be given information on the place of birth and information on transfer arrangements.

- 6.13 These studies highlight the need to discuss in detail the benefits and risks associated with the parent'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 should be discussed following careful assessment of need and risk and agreed between the woman, her partner 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 birth must be explained to women (antenatally) to allow them to make an informed clinically appropriate choice about place of birth.
- 6.14 The decision as to where 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.

Objective 16

Women will be supported to make an informed decision about their place of birth by providing a balanced description of the benefits and risks of the different types of maternity settings. This will include information on midwife-led units, homebirth and consultant-led units.

- 6.15 Regardless of place of birth it is recognised best practice that women should be treated with respect and should be in control of and involved in what is happening to them. Women should have 1:1 midwifery care in established labour. Northern Ireland has a good record of achieving this level of care and commissioners and providers must ensure that this is maintained.
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Midwife-led Units⁴⁴

- 6.16 Midwife-led units are maternity units run solely by midwives. They can either stand alongside a consultant-led unit or be freestanding. It is important that clear protocols are in place for assessment of suitability for giving birth in a midwife-led unit, and for effective stabilisation and transfer to a consultant-led 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.
- 6.17 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 obstetric-led units to allow rotation of staff to facilitate this. Similarly all midwives working within obstetric-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.
- 6.18 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.

Consultant-led Units⁴⁵

- 6.19 Those women who are likely to require intervention from an obstetrician, anaesthetist or neonatologist/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.
- 6.20 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.

44 Birthplace terms and definitions: Part 2 Nov 2011 pg 12 (See glossary)

45 Birthplace terms and definitions: Part 2 Nov 2011 pg 12 (See glossary)



- 6.21 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 guidance⁴⁶ 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, there is a 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 by resident middle grade doctors of at least the competency of ST3⁴⁷ level or other healthcare professional trained to an equivalent level. This will ensure 24-hour cover for the labour ward, appropriate anaesthetic cover for pain relief, elective lists and emergencies in line with NICE guidance⁴⁸ (30-minute decision to delivery for emergency caesarean section) and appropriately trained neonatologists/paediatricians in case of neonatal problems at birth. There should also be sufficient availability of midwives to ensure 1:1 care in established labour at all times.
- 6.22 The current configuration of maternity units means that the majority of women are within one hour's drive of a maternity unit. This level of access to maternity services is supported. In moving forward, the future pattern of service provision needs to take account of the role of midwife-led units in promoting an appropriate balance between local access to services and the need to provide more specialist care in units. Fundamental to decision making at local level is local engagement in the development of population plans by Local Commissioning Groups (LCGs)/HSC Board. These plans will underpin future commissioning arrangements. When considering the model of maternity care appropriate to local needs, LCGs and providers will need to take account of the evolving evidence base on the effectiveness of services, together with other key strategic priorities and statutory obligations including:
- improving and protecting health and wellbeing, and reducing inequalities;
 - the safety and quality of care;
 - deliverability and sustainability of any proposed model;
 - the effective use of resources;
 - innovative, responsive and accessible services, including geographical access;

46 NICE Clinical Guideline (CG55), *Intrapartum Care*, 2007.

47 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 speciality.

48 NICE Clinical Guideline (CG13), *Caesarean Section*, 2004.



- stakeholder support, for example, public, clinical and organisational support; and
- protecting the most vulnerable in society, including children and adults at risk of harm.

6.23 A change in the model of maternity care is inevitable; this will need to complement the broader aspects on the reconfiguration of community and hospital services, as outlined in *Transforming Your Care*. Where small units exist LCGs/HSC Board and 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. HSC organisations will consider how best to maximise choice for local women and, where appropriate, develop a regional networked approach with cross boundary flows between Trusts, and other jurisdictions. Such an approach may improve local access and enhance care for women. It may also make some midwifery-led units more sustainable while, at the same time, reduce pressures on other units including some consultant-led units.

Objective 17

The HSC will consider how best to maximise choice in intrapartum care, while also meeting other key priorities and statutory obligations. A networked approach to maternity care, with cross-boundary flows between HSC organisations, and possibly other jurisdictions, will be necessary.

6.24 However, in some instances, it may mean that those women whose pregnancy or birth 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 are available at these specialist units.



- 6.25 For a small minority of women there is a need for very highly specialist care, the Royal Jubilee Maternity Service located in the Belfast Trust will remain as a regional maternity unit for the most complex cases, and must have sufficient capacity to meet the needs of the local population and to provide a tertiary service for Northern Ireland.

Objective 18

Where a consultant-led unit is provided, a midwife-led unit will be available on the same site. As well as providing services for the local population, the Belfast Trust will provide the regional centre for Northern Ireland to care for the most complex cases.

- 6.26 There will be a move towards a maternity service model providing accessible local midwife-led services or home birth for those women for whom such care is appropriate and sustainable consultant-led care for those other women who need it.

Objective 19

Freestanding midwife-led units will be considered as an option for the provision of accessible, high quality, sustainable, and effective maternity care.

Interventions

- 6.27 Just over half of the 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.



A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 62



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%
Northern Ireland ¹	25,915	56.2%	13.5%	29.9%

Source: Child Health System¹

²Downe MLU opened on 22nd March 2010.

- 6.28 A woman's whole reproductive life should be considered as a continuum when agreeing care options. While it is recognised 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. All staff involved in the delivery of services will be supported to make use of the best evidence from research, to highlight issues on which the necessary evidence for practice is not yet available, and to engage with research to provide the evidence.



Objective 20

Inappropriate variation in practice will be reduced by examining all intervention rates, and benchmarking against comparable units across Northern Ireland, the rest of the UK and Republic of Ireland.

Support for women suffering stillbirth or neonatal death

- 6.29 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.
- 6.30 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 undertaken for development of this strategy and 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 Death⁴⁹ and the Department's Post Mortem Examinations - Good Practice Guide in Consent and the Care of the Bereaved⁵⁰.

Summary

- 6.31 This chapter outlines the current models of maternity service provision in Northern Ireland. Just over 55% of births are normal births. There is unexplained variation in practice when compared to other regions in the UK and Ireland. It presents recent research evidence which would contribute to decision-making on what and how local service provision might best be achieved. A culture of normalisation of birth has the potential to reduce unnecessary interventions and improve the birthing experience for the parents, baby and family. Unfortunately, tragedies do happen. The importance of advice, information and support through the bereavement period is recognised.

49 DHSSPS, *Careplan for women who experience a miscarriage, stillbirth or neonatal death*, 2005.

50 DHSSPS, *Postmortem Examinations - Good Practice Guide in Consent and the Care of the Bereaved*, 2005.



Chapter Seven – Postnatal Care

Outcome: Appropriate advice, and support for all parents and baby after birth.

Introduction

7.1 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, many within 24 hours. However, the length of time varies across Northern Ireland. Timing of transfer home following birth in a hospital or MLU should be dependent on the clinical need of the woman and her baby. 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 MLU 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 2 February 2011.



- 7.2 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 women who have a normal birth now go home within 24 hours, women or babies who remain longer 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 to ensure that these women are appropriately monitored. The opportunity for women to discuss their maternity experience with HSC staff, especially in regard to any complications that arose, should also be taken at this time.
- 7.3 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.
- 7.4 NICE guidelines on routine postnatal care of women and babies⁵¹ 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*⁵² 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, supporting breastfeeding, 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 there is a 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 and postnatal 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. A ratio of one midwife to every 28 births should allow adequate midwives for hospital and community care.

51 NICE Clinical Guideline (CG37), *Routine postnatal care of women and their babies*, 2006.

52 DHSSPS, *Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years*, 2010.



- 7.5 The potential to improve health and well-being for both mother and baby during the postnatal period is significant. A recent UK survey⁵³ of service-users highlights inadequacies in the current provision of postnatal care and how some mothers struggle to cope. Some organisations have highlighted these issues and have put in new programmes to support parents. However, the report compiled locally by the Patient and Client Council which informed this strategy noted that women were particularly happy with the postnatal care they received from the community based midwifery team.
- 7.6 NICE guidelines on postnatal care⁵⁴ 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*⁵⁵ (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 birth. 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.
- 7.7 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, for example, SureStart and breastfeeding support groups. There is strong evidence of the importance of parental interaction for infant brain development, *Healthy Child, Healthy Future*⁵⁶, reflects new evidence⁵⁷ that has emerged about neurological development and the importance of forming strong parent-child attachment in the first years of life. This knowledge should inform the provision of antenatal education and postnatal support.
- 7.8 Communication between the hospital of birth, the community midwifery team and the woman's general practitioner regarding her birth 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.

53 NCT, *Postnatal Care – Still A Cinderella Story?*, 2010.

54 NICE Clinical Guideline (CG37), *Routine postnatal care of women and their babies*, 2006.

55 Lewis, G (ed), Centre for Maternal and Child Enquiries (CMACE), *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer – 2006-2008*, 2011.

56 DHSSPS, *Healthy Child, Healthy Future, A Framework for the Universal Child Health Promotion Programme in Northern Ireland, Pregnancy to 19 Years*, 2010.

57 Hosking, G, *The Hand that Rocks the Cradle*, 2003.



- 7.9 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 the book, *Birth to Five*⁵⁸. A documented, individualised postnatal care plan incorporated into the maternity hand-held record should be developed with each woman.
- 7.10 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; therefore, good communication between the midwife and GP will be essential. Transfer of the woman's care to the Health Visiting service will take place when clinically appropriate but it will be usually around 10 days. Again communication from the midwife to the health visitor will be essential to ensure continuity of care for the women in the postnatal period.
- 7.11 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.

Objective 21

Postnatal care, provided by the maternity team in the community, will offer a woman-centred home visiting schedule which will be responsive to need for a period of not less than 10 days and will include visiting by midwives and maternity support workers.



- 7.12 There is good evidence that breastfeeding improves the physical and emotional health of women and babies. The WHO recommends that babies should be exclusively breastfed for 6 months. The breastfeeding statistics for Northern Ireland show that around two thirds (64% in 2010⁵⁹) of women start breastfeeding their baby but that this number falls dramatically over the following few weeks. *A Ten-year Breastfeeding Strategy for Northern Ireland (2012-2022)* has been recently published for consultation; once finalised 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 there is a need to ensure that correct support is available to reduce these barriers. Midwives and health visitors have a strong role to play in this. Women will be encouraged and supported to breastfeed their baby for up to six months and beyond.
- 7.13 The woman's maternity care is completed after six weeks and at this stage she should have a postnatal appointment with the appropriate clinician(s); for example, an obstetrician or GP. This visit provides follow up care for conditions which may have complicated the pregnancy, for example, diabetes, hypertension, anaemia or mental health issues. The postnatal visit also provides an opportunity for early intervention and counselling on postnatal depression.
- 7.14 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, healthy diet and rubella immunisation if needed.

Objective 22

Women should be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician(s).

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 69



Summary

- 7.15 There is variation in the length of stay in hospital following vaginal birth or caesarean section. Postnatal care could be improved upon as it is a real opportunity to provide information and support to parents. Breastfeeding will be promoted. Support will be tailored to individual needs in regard to, for example, future pregnancy and sexual health, clinical conditions, and emotional health. The maternity team will offer postnatal care in the community. This will be a woman-centred home visiting schedule for a period of not less than ten days and will include visiting by midwives and maternity support workers. Women will be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician.





Chapter 8 – Implementation

Introduction

- 8.1 The purpose of this chapter is to outline how this strategy will be implemented in Northern Ireland. In this context, the Department is asking the HSC Board (HSCB) and the Public Health Agency (PHA) to co-lead implementation, working in partnership with other HSC organisations, the public, and voluntary and third sector organisations. It is essential that each HSC provider plays its part in the implementation of this strategy. Through the development of Integrated Care Partnerships (ICPs) a real opportunity would be created for provider organisations to work together to improve outcomes for women and their babies.
- 8.2 In order to drive implementation forward, both the PHA and HSCB should nominate a lead individual who will be jointly responsible for taking forward implementation. It is also expected that each Trust will have a named individual to co-ordinate action within the Trust. It is recommended that a regional Action Plan and formal implementation process be put in place.
- 8.3 The main outcomes associated with this document are:
- give every baby and family the best start in life;
 - effective communication and high-quality maternity care;
 - healthier women at the start of pregnancy (preconception care);
 - effective, locally accessible, antenatal care and a positive experience for prospective parents;
 - safe labour and birth (intrapartum) care with improved experiences for mother and babies; and
 - appropriate advice, and support for parents and babies after birth.
- 8.4 Each of the above outcomes has associated objectives (22 in total). It is recommended that these should be incorporated into an Action Plan. This will be an opportunity to document ‘time-bounded’ actions relevant to the objective, and there should be outcome measures to demonstrate continuous progress. Where appropriate to do so, these should be linked to other outcome measures; for example, those contained in the forthcoming public health framework or the Children’s and Young Persons’ Service Framework (unpublished).



- 8.5 Whilst many of the maternity outcomes and objectives are stand-alone, the inter-dependency of some of them with other policies and strategies is recognised. This is particularly relevant to the proposals set out in *Transforming Your Care* (TYC) in relation to the promotion of self-care, local service provision, and the development of acute hospital networks. To this end, the HSC Board/PHA should take account of the principles outlined in TYC (Appendix Two refers) when considering the content of an Action Plan. This Action Plan should be submitted to the Department by 31 January 2013.

Performance Measures

- 8.6 All outcomes and related objectives should be accompanied performance measures which should be reported upon as part of a short annual report on progress towards implementation. Examples of performance measures are included below. However, the Implementation Group will wish to give due consideration to measures which will demonstrate the spectrum of progress towards implementation of the outcomes, and associated objectives.

Finance

- 8.7 Total expenditure returned by HSC Trusts for the programme of care on Maternity and Child Health in 2010 -11 was £147m. Of this, the approximate expenditure relating to maternity hospital services and community midwives was £99m. Further investment in the reconfiguration of maternity services will be part of the *Transforming Your Care* programme. It is recognised that effective ICT systems are “enablers” in this wider reform programme.
- 8.8 Work is also underway to build a new maternity facility, linked to the critical care building, on the Royal Group of Hospitals site in the Belfast Trust. The combined investment is £200m. In addition, the South Eastern Trust will submit a business case to the DHSSPS in 2012 to extend the existing maternity provision at the Ulster Hospital, Dundonald.



A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Accountability

8.9 Accountability for implementation of this Strategy rests with the HSCB/PHA, with Local Commissioning Groups and HSC Trusts all playing their part. The Department will monitor progress through normal accountability processes for HSC Board/PHA and HSC Trusts. To inform this process a short regional annual report on progress against the Action Plan should be sent to the Head of Healthcare Policy Group.

8.10 Below are the six main outcomes and associated objectives which will assist in the formation of an Action Plan.

OUTCOME	OBJECTIVES	EXAMPLES OF MEASURES OF PERFORMANCE
Give every baby and family the best start in life (Chapter One)	1. A universal approach to major public health messages for women and girls of childbearing age will be promoted. This includes the importance of healthy life styles, and a focus on the social factors and clinical conditions which are known to have an adverse impact on outcomes for mother and baby	<ul style="list-style-type: none"> • Reduction in % of pregnant women who are smokers, at booking. • Reduction in % of pregnant women who are obese at booking. • Reduction in % of teenage pregnancies. • Reduction in % of pregnant women who misuse alcohol or drugs.
Effective communication and high-quality maternity care (Chapter Three)	2. A culture of 'normalisation' of pregnancy and birth will be promoted as part of population planning and the commissioning and provision of maternity care. The principles outlined in <i>Transforming Your Care</i> will inform how access to maternity services and maternity care is best promoted and provided.	<ul style="list-style-type: none"> • All LCGs and other members of local health economies have incorporated evidence-based maternity care, and the commissioning specification for maternity services, into population-planning processes. • % reduction in variation of obstetric interventions, for example, caesarean sections.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



OUTCOME	OBJECTIVES	EXAMPLES OF MEASURES OF PERFORMANCE
<p>Effective communication and high-quality maternity care (Chapter Three) CONT'D</p>	<p>3. Prospective parents will be considered as partners in maternity care and given all relevant information, in appropriate formats, to make informed choices about what is best for them and their baby.</p> <p>4. A maternity communication protocol/pathway will be developed outlining the principles for communication and information-sharing across the primary, community and hospital interface. As part of this process, each should understand respective roles and responsibilities especially on 'who' and 'how' a pregnant woman contacts the health service in the event of a concern or clinical emergency.</p> <p>5. Maternity services must show good clinical leadership and communication, including in the use of the maternity hand-held record, Labour Ward Forum and other multidisciplinary groups.</p> <p>6. Work will progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.</p> <p>7. The NIMAT system will be continually reviewed and updated to ensure it is 'fit for purpose' to promote coordinated regional data collection, in line with data protection principles and information governance.</p>	<ul style="list-style-type: none"> • Increase in % of women with long-term physical and mental health conditions given relevant information about pregnancy and informed choice. • Evidence of communication protocol development and usage. • Evidence that each Trust has an active audit programme, labour ward forum and proactive interface with Maternity Services Liaison Committee. • Development and implementation of regional dashboard. • Evidence of updating and use of regional data through the NIMAT system.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Page 74

OUTCOME	OBJECTIVES	EXAMPLES OF MEASURES OF PERFORMANCE
<p>Healthier women at the start of pregnancy (preconception care) (Chapter Four)</p>	<p>8. 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 will be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management.</p> <p>9. A clear pathway of care will be available for individuals with long-term conditions who are planning a pregnancy and throughout the pregnancy.</p>	<ul style="list-style-type: none"> Tailored information on the effects of pregnancy on long-term conditions such as diabetes, epilepsy and depression, and their usage in GP surgeries and specialist clinics. Regional pathway development for long-term conditions during pregnancy, for example, diabetes, hypertension, and depression.
<p>Effective, locally accessible, antenatal care and a positive experience for prospective parents (Chapter Five)</p>	<p>10. When a woman becomes pregnant she will be facilitated to make early direct contact with a midwife.</p> <p>11. There will be appropriate access to booking scans, and the NIMAT system in community and non-acute hospital settings.</p> <p>12. For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the local community.</p> <p>13. Women with complex obstetric conditions will have care led by a consultant obstetrician.</p> <p>14. Women will 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 Maternity Assessment Unit.</p>	<ul style="list-style-type: none"> % of women who have contacted a midwife before 10 weeks gestation % of women who self-refer to midwife. % of women who say they had a midwife who they were able to contact with questions and for advice. Audit of pregnant women with complex conditions, for example, diabetes, to assess rapid referral by GP or midwife, and timely consultant assessment. Audit of usage of Maternity Assessment Unit.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



OUTCOME	OBJECTIVES	EXAMPLES OF MEASURES OF PERFORMANCE
<p>Effective, locally accessible, antenatal care and a positive experience for prospective parents (Chapter Five) CONT'D</p>	<p>15. Antenatal education will be enhanced and active involvement of prospective parents will be encouraged; this education will primarily 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.</p>	<ul style="list-style-type: none"> • Survey of service-user satisfaction with services. • Development of an e-learning programme to complement messages obtained in antenatal classes.
<p>Safe labour and birth (intrapartum) care with improved experiences for mothers and babies (Chapter Six)</p>	<p>16. Women will be supported to make an informed decision about their place of birth by providing a balanced description of the benefits and risks of the different types of maternity settings. This will include information on midwife-led units, homebirth and consultant led units.</p> <p>17. The HSC will consider how best to maximise choice in intrapartum care while also meeting other key priorities and statutory obligations. A networked approach to maternity care, with cross-boundary flows between HSC organisations, and possibly other jurisdictions, will be necessary.</p> <p>18. Where a consultant-led unit is provided a midwife-led unit will be available on the same site. As well as providing services for the local population, the Belfast Trust will provide the regional centre for Northern Ireland to care for the most complex cases.</p>	<ul style="list-style-type: none"> • % of women giving birth in different maternity settings. • All women given information about options for maternity care and individual benefits and risk. • Collaboration between HSC organisations, on the promotion of clinically appropriate choice in maternity care for women.

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



Page 76

OUTCOME	OBJECTIVES	EXAMPLES OF MEASURES OF PERFORMANCE
<p>Safe labour and birth (intrapartum) care with improved experiences for mothers and babies (Chapter Six) CONT'D</p>	<p>19. Freestanding midwife-led units will be considered as an option for the provision of accessible, high-quality, sustainable, and effective maternity care.</p> <p>20. Inappropriate variation in practice will be reduced by examining all intervention rates, and benchmarking against comparable units across Northern Ireland, the rest of the UK and the Republic of Ireland.</p>	<ul style="list-style-type: none"> • Each Trust has a workforce plan and training plan which demonstrates clearly that all maternity staff have received appropriate training. • Regional audit on intervention rates, and participation in national audit, as appropriate.
<p>Appropriate advice, and support for parents and baby after birth (Chapter Seven)</p>	<p>21. Postnatal care, provided by the maternity team in the community, will offer a woman-centred home visiting schedule which will be responsive to need for a period of not less than 10 days and will include visiting by midwives and maternity support workers.</p> <p>22. Women will be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician(s).</p>	<ul style="list-style-type: none"> • Taking account of the recommendations made in Birthrate Plus on the ratio between midwives and MSWs, the skill mix of staff in the community. • There is a training programme for MSWs based on an agreed framework for delegation of tasks in the postnatal period. • Postnatal experience included in a satisfaction survey. • % of women breastfeeding at 10 days postnatally.



Appendix One

Transforming Your Care

Summary of Key Proposals Relating to Maternity Services

1. Written and oral information for women to enable an informed choice about place of birth.
2. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.
3. Services in consultant-led obstetric and midwife-led units available dependent on need.
4. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.
5. Continuity of care for women throughout the maternity pathway.
6. A regional plan for supporting mothers with serious psychiatric conditions.



Appendix Two

Transforming Your Care

12 Major Principles of Change

The Review identified 12 major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any models by promoting a better outcome for the service-user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care - working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.



Appendix Three

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 of Neonatal Network)
- Member: Mrs Elizabeth Bannon
(Co-Director of Maternity Services, Belfast HSC Trust)
- Member: Professor Martin Bradley
(Chief Nursing Officer, DHSSPS until 10 June 2011)
- Member: Dr Maura Briscoe
(Director Secondary Care Directorate, DHSSPS from 12 May 2011)
- Member: Dr Grainne Doran
(Vice-Chair, NI Council Royal College of General Practitioners)
- Member: Mr David Galloway
(Director Secondary Care Directorate, DHSSPS until 30 September 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
HSC Trust) (Alternative: Dr Greg Furness, Consultant Anesthetist,
Northern HSC Trust)
- Member: Ms Maeve Hully
(Patient and Client Council)

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 80



- Member: Dr Lorraine Johnston
(Consultant Obstetrician, Northern HSC 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 HSC Trust)
- Member: Dr Mary Murnaghan
(Head of Obstetrics & Gynaecology, Northern Ireland Medical & Dental
Training Association)
- Member: Mr Seamus McGoran
(Director of Acute Services South Eastern H&SC Trust)
(Alternative: Mrs Eileen McEaney)
- Member: Dr Miriam McCarthy
(Deputy Secretary, Health Policy Group, DHSSPS until 28 February 2011
and Director of Secondary Care, DHSSPS until 11 May 2011)
- Member: Dr David McManus
(Medical Director, Northern Ireland Ambulance Service)
- Member: Mr Francis Rice
(Director of Nursing, Southern HSC Trust
(alternative: Mrs Anne McVey)
- Member: Dr Nigel Ruddell
(Assistant Medical Director, Northern Ireland Ambulance Service)
- Member: Mr Dean Sullivan
(Director of Commissioning, HSC Board)
- Member: Ms Verena Wallace
(Local Supervisory Authority Midwifery Officer (LSAMO), PHA)
- Member: Dr Paddy Woods
(Deputy Chief Medical Officer, DHSSPS)
-

A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 81



Project Team

- Member: Mrs Denise Boulter
(Midwifery Officer, DHSSPS until August 2011)
- Member: Ms Brenda Devine
(Midwifery Officer, DHSSPS from September 2011)
- Member: Dr Heather Livingston
(Senior Medical Officer, DHSSPS)
- Member: Ms Siobhan McKelvey
(Secondary Care Directorate, DHSSPS until 30 September 2010)
- Member: Ms Joan Hardy
(Secondary Care Directorate, DHSSPS from 1 October 2010 until
Jan 2012)
- Member: Mrs Margaret Rose McNaughton
(Head of Regional Services, Secondary Care Directorate, DHSSPS until
February 2012)
- Member: Mrs Michelle Connor
(Secondary Care Directorate, DHSSPS from February 2012)
- Member: Dr Maura Briscoe
(Director of Secondary Care, DHSSPS from April 2012)
-



Appendix Four

Maternity Pathway for straightforward pregnancies

(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.	—————→	Refer to obstetrician or other specialist
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.	← - - - - - —————→	
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.	← - - - - - —————→	
25wks	Antenatal examination (first baby only). Risk assessment to ensure appropriate care.	← - - - - - —————→	
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.	← - - - - - —————→	

Complexity or risk identified —————→ Risk managed ← - - - - -

A Strategy for Maternity Care in Northern Ireland 2012 - 2018



31wks	Antenatal examination (first baby only).	← - - - - -	Refer to obstetrician or other specialist
	Risk assessment to ensure appropriate care.	—————→	
34wks	Antenatal examination – information regarding labour and parenting.	← - - - - -	
	Risk assessment to ensure appropriate care.	—————→	
36wks	Antenatal examination.	← - - - - -	
	Risk assessment to ensure appropriate care.	—————→	
38wks	Antenatal examination.	← - - - - -	
	Risk assessment to ensure appropriate care.	—————→	
40wks	Antenatal examination (first baby only).	← - - - - -	
	Risk assessment to ensure appropriate care.	—————→	
41wks	Antenatal examination.	← - - - - -	
	Refer to obstetrician for induction of labour date.	← - - - - -	

Complexity or risk identified —————→ Risk managed ← - - - - -





Appendix 5

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Page 85



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Page 86



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Page 87



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Page 88



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Appendix Six

Glossary; and National Standard Setting Organisations

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.

Consultant Led Unit

Obstetric unit (OU): an NHS/HSC clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day.

NICE

The National Institute for Health 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.

Midwife Led Units⁶⁰

- a) **Alongside midwifery unit (AMU):** an NHS/HSC clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair.
- b) **Freestanding midwifery unit (FMU):** an NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General



Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance.

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.

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 five 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.



A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 91



Ultrasound scans

Most women are offered at least two ultrasound scans during their pregnancy. The first is usually around 8-14 weeks pregnant and is sometimes called the booking scan, because it can help to determine when the baby is due. The second scan usually takes place between 18 weeks and 20 weeks, 6 days. It is called the anomaly scan because it checks for structural abnormalities in the baby.



A Strategy for Maternity Care in Northern Ireland 2012 - 2018

Page 92



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