HSC Public Health Agency

NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery

PHASE TWO (Postnatal)

Describe current provision and propose models of community maternity care for the implementation of

A Strategy for Maternity Care in Northern Ireland (2012-2018)

Project Plan

INVESTORS IN PEOPLE

CONTENTS

DESCRIBE CURRENT AND PROPOSE MODELS OF COMMUNITY MATERNITY CARE

1.0 INTRODUCTION

1.1 Over the past 10 years, the role and contribution of midwifery to the Maternity Services has changed and developed dramatically. This change has been supported by policy drivers such as *Midwifery 2020 - Delivering Expectations*[1] a four country strategic vision. This policy outlined the contribution midwives make to achieving quality and cost effective maternity services. However, there has been a significant decline in the input of providing some accepts of maternity care from the General Practitioner.[2]

1.2 The current model of community maternity care in Northern Ireland (NI) largely operates within a traditional model of care. That is, there is a tendency to rely on women to present themselves to their General Practitioner as the first point of contact. However, according to *Midwifery 2020*[1] 'midwives should have a visible place in a community setting where women can choose to access them as the first point of contact'. Some changes to the traditional model have taken place here, however, this mainly depends on where women live.

1.3 *A Strategy for Maternity Care In Northern Ireland (2012 - 2018)*[3] endorses the key messages from *Midwifery 20:20* and plans to shape and refine current service delivery. In addition other important strategic drivers such as *Quality 2020 (2010)*[4] and *Fit and Well- Changing Lives (2012)*[5] a Public Health Strategy will affect the future services.

1.4 The rethink of maternity care provision must take into consideration where care is best provided and if it can be supported by the use of tele-health and telecare technologies (Ham et al 2012)[6]. The rapidly changing pattern of need in N.I.[7] and *Transforming Your Care*[8] presents significant implications for the provision and funding of all services especially against a backdrop of societal, demographic and birth-rate changes in the future. All of these aspects are important, coupled with the messages and lessons from the Inquiry into *Mid-Staffordshire Report* (Francis 2013)[9], Kirkup (2015)[10] and Willis (2014)[11].

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[1] Midwifery 2020 - Delivering Expectations - Four country publication 2010
[2] The Kings Fund (2010) The role of GPs in maternity care – what does the future hold? London
[3] DHSSPS A Strategy for Maternity Care in Northern Ireland 2012 - 2018
[4] DHSSPS Quality 2020 (2010) Belfast
[5] DHSSPS 2012 Fit and Well - Changing Lives 2012-2022, Public Health Strategy Belfast
[6] Ham et al (2012) Transforming the delivery of Health and Social Care - The case for fundamental change The Kings Fund
[7] McKinsey and Company. (2010). *'Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review.'* Belfast, DHSSPSNI. Available for download at: http://www.dhsspsni.gov.uk/2010-hsc-spending-review-implications.pdf
[8] Transforming Your Care - *A Review of health and Social Care* in Northern Ireland (2011)
[9] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
[10] The Report of the Morecambe Bay Investigation March 2015 Dr Bill Kirkup CBE
[11] Raising the Bar (2015) *Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* Lord Willis, Independent Chair - Shape of Caring review Health Education England

1.5 Through the Office of the Chief Nursing Officer, Department Health Social Services and Public Safety (DHSSPS), the Public Health Agency (PHA) has approached the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to work in partnership with Health and Social Care colleagues to describe current provision and propose new models of community maternity care in preparation of the implementation of the Maternity Care Strategy. This has led to the establishment of the Community Maternity Care project (Antenatal and Postnatal) this project plan focuses on postnatal care.

2.0 BACKGROUND

2.1 The delivery of maternity services currently takes place within a range of challenging contexts were the multi-professional/multidisciplinary workforce is its most valuable asset. The challenges posed by *A Strategy for Maternity Care*[2], include how and where the resource for Maternity Care and in particular the models of care should be delivered to provide, quality, safe and effective services to women, and their families.

2.2 Research has shown that there can be considerable variation in maternity care[12]. It has also been demonstrated that high quality maternity care significantly contributes to the health and well-being of the woman and her baby. N.I. takes pride in the service it delivers to women, but it is generally recognised more can be done.

2.3 Phase one of this project addressed the area of Antenatal Care and the outputs developed will hopefully be 'signed off' through the overarching Maternity Strategy Implementation Group – (MSIG) at the meeting in February 2016. An implementation period will be planned for the four products, namely:

1. Choices leaflet/ Poster Campaign and APP
2. Regional Referral Letter
3. Antenatal Core Care Pathway –This pathway will be incorporated into the Maternity Hand Held Record and a workshop to address this is being planned for Feb 2016.
4. Regional CCG System Electronic Letter

2.4 This phase addresses the postnatal care and will take into consideration a number of very informative reports[13] Midwives are often described as being the backbone to community maternity service delivery. They have a major role to play in public health issues and can be the coordinator of care during a woman's pregnancy through to postnatal care. However, it has been widely recognised that the skills midwives are trained and capable of performing are often under-utilised. On the other hand the role of the general practitioner in maternity care has declined

[12] Patterns of Maternity Care in English NHS Hospitals2011/12
[13] Community Maternity Care Phase One Engagement report (2013)/ Public Health Agency 10,000 Voices Initiative/ Queens University Belfast (QUB:2015) Survey of Women's experiences of Maternity Care NI

somewhat over the years[14]. Nevertheless they still remain responsible for a women's general medical care over her life span. However we know in the postnatal period generally women will attend their GP for this 6 week visit, but in some cases this is left to the women to organise resulting in some not attending. This is a crucial time especially for those public health messages to be conveyed relating to pre-conceptual care and advice.

2.5 *A Strategy for Maternity Care*[15] recognises this and has clearly identified the vision and the future direction. Outlined within this policy, there are 22 objectives for implementation with an associated timeline up to, and including 2018. This second phase of the project will concentrate on the objectives in the *Maternity Strategy* referring to the postnatal period and aspects of care that are related. It also aims to establish the current state of preparedness in terms of skills and competencies of the midwifery and general practitioner workforce to regionally achieve the objectives.

2.6 Throughout this phase, the project will seek to define the current provision of postnatal care in community settings and propose new models of for implementation. This will include the interfaces with all health professionals, midwifery, health visiting, social services and general practice, taking into consideration *Healthy Child, Healthy Future - A Framework for the Universal Child Health Promotion Programme (2010)*[16].

2.7 As outlined in phase one of the project, phase two will also concentrate mainly on the roles of midwives, general practitioners and the potential contribution of skill mix through the employment of maternity support workers in the community.

2.8 The overarching aim of phase two of the project is to address two objectives from *A Strategy for Maternity Care (DHSSPS 2012):*

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*
	and
objective 22	*Women will be advised and encouraged to attend their six week postnatal appointment with the appropriate clinicians*

[14] The role of GPs in maternity care – what does the future hold? Alex Smith Judy Shakespeare Anna Dixon
[15] DHSSPS - A Strategy for Maternity Care (2012-2018)
[16] Healthy Child, Healthy Future A framework for the Universal Child health promotion Programme in Northern Ireland (2010)

3.0 PROPOSED PROJECT PLAN – AIM, SCOPE AND OBJECTIVES

3.1 *Aim*

The overarching aim of the project is to:

Describe and assess current models of postnatal community maternity care with the purpose of proposing regional models and the competency and skills requirements for the workforce, in order to facilitate the implementation.

Scope

3.2 The scope of the project is outlined below:

I. Conduct a regional review of the models of postnatal maternity care currently being provided in community by location, percentage of attendance of women, frequency of and content of contact, provision of the 6 weekly postnatal visit and include a review of skill mix - (i.e. maternity support worker)

II. Review the various reports and initiatives[17] relating to any issues raised regarding postnatal care and if necessary, engage with women and their families through various methods (e.g face to face, survey monkey) to seek their views on current and future postnatal maternity care and support in the community setting

III. Conduct a retrospective regional maternity community (rural and urban) workforce review between Jan 2015 to Jan 2016 to include:

- head count and whole time equivalent per location
- head count and whole time equivalent by work patterns
- head count per whole time equivalent caseload
- age profile, in order to facilitate succession planning
- community indicators identifying types of care and support provision

IV. Review current care and support provision in the postnatal period with an aim to develop a regional model to achieve the identified objectives.

V. Examine the impact on services within the community maternity settings to include the effect of reduced length of stay in hospital, maternal complexities, increasing diversity in the migrant population, type of birth including homebirth and increase in caesarean section rates, safeguarding issues and admissions or readmissions for postnatal mothers and babies

[17] Community Maternity Care Phase One Engagement report (2013)/ Public Health Agency 10,000 Voices Initiative/ Queens University Belfast (QUB:2015) Survey of Women's experiences of Maternity Care NI

VI. Describe and assess the effectiveness of all forms of communication (inclusive of IT) in maternity care in relation to referral patterns and interfaces in the community, between midwives, general practitioners, health visitors, social services and other services e.g – neonatal/children's.

VII. Review current information available to women through Trust Websites, PHA, (including *The Pregnancy Book*) NHS Choices and the maternity hand held record. Developing suggestions for future work.

Objectives

3.3 The following objectives are designed to produce the outcomes required to complete the overarching aim of the project:

i) Develop and agree models for implementation of evidence based holistic postnatal care in the community setting from birth and transfer from hospital settings through to 6 week postnatal visit

ii) Develop and agree a normative range of caseload per whole time equivalent midwife in the community setting (rural and urban) with the possible input of care from the maternity support worker

iii) Develop and agree a communication strategy to include referral patterns and the interfaces between midwives, health visitors, general practitioners, obstetricians and others.

iv) Agree the essential supporting resources required to provide postnatal maternity care in the community settings.

v) Communicate service developments to the wider public.

4.0 METHODOLOGY OVERVIEW

4.1 Phase two of the project will run from January 2016 to March 2017. The established Steering Group, chaired by Eileen McEneaney, Executive Director of Nursing, will continue to meet approximately every two months during this second phase which has representation drawn from the five HSC Trusts, PHA, DHSSPS, NIPEC, Educational Providers, Patient and Client Council - Maternity Services Liaison Committees, Royal College of General Practitioners, Royal College of Obstetricians and Gynaecologists and Royal College of Midwifery. Membership and Terms of Reference are included at Appendix one. NIPEC will continue to host the meetings, assessing and reviewing administrative support to the Steering Group meetings.

4.2 The Steering Group will agree and oversee the Project Plan for phase two. The established Working Group will remain in order to achieve the aim and objectives. A work programme will be developed and encompass the following methodologies:

4.2.1 Literature reviews to be conducted to determine:

(a) Options for models of postnatal Maternity Care in a community setting

(b) Provision of resources including tele-health / tele-care technologies that will enable an evidence based holistic approach to postnatal maternity care in a community setting

4.2.2 If decided, agree a set of semi structured interviews and or questionnaires to be conducted with HSC Trust partners including General Practitioners to gather information in relation to workforce, caseload, and the range of postnatal maternity care provision in community settings. Once data collection tool agreed it will be communicated formally to all stakeholders.

4.2.3 Review the Engagement Report conducted in phase one (Community Maternity Care), the recent QUB Report into women's experiences and the 10,000 Voices Initiative into issues regarding the postnatal period and if necessary agree additional enagement.

4.2.4 Formal contact and agreed information from the experience of national and international expertise should be gathered to inform the work of the project in terms of the range and scope of models of maternity care in community settings.

4.3 It is intended to deliver this phase of the project over a period of 15 months. The continuation of this project will feed into the overall implementation of the 22 objectives within *A Strategy for Maternity Care*, through the Regional Maternity Services Implementation Group at the Public Health Agency (PHA).

4.4 A work programme for this phase of the project is attached at Appendix two, that has been designed to achieve the objectives of the project.

5.0 RESOURCES

5.1 Support and co-ordination for the project will be provided by NIPEC within its own resources, assisted by staff from the PHA.

5.2 Participating organisations will undertake that relevant staff be released for the timeframe of the project for all required meetings and will also be responsible for support and facilitation throughout the project where testing is required within their organisation.

6.0 EQUALITY AND GOVERNANCE SCREENING

6.1 To ensure NIPEC and its stakeholders are meeting its legal obligations and responsibilities under various Equality and Governance areas, the project plan,

its aims and objectives and outcomes have been examined and screened for any issues relating to the following areas:

- Risk Management
- Equality and Human Rights
- Privacy Impact Assessment (PIA)
- Personal Public Involvement (PPI)

6.2 A summary of these considerations and any action required is documented in Appendix Three.

7.0 EVALUATION

7.1 The project will be evaluated on an on-going basis, evidenced through the audit trail provided by notes of meetings of the Steering Group. NIPEC and the PHA will be responsible for the quality of the products of the project.

8.0 COMMUNICATION AND DISSEMINATION

8.1 Communication and consultation with relevant and appropriate stakeholders will be on-going throughout the project, using various mechanisms such as email, teleconferencing facilities and face-to-face meetings. The NIPEC website will update pages online according to the progress of the project.

8.2 Approved notes and communiqués of the Steering Group meetings will be circulated to respective group members.

8.3 Dissemination of the Final Report of the project will be the responsibility of the PHA. Implementation of the products of the project will be the responsibility of the PHA in partnership with the HSC Trusts. The PHA will share the Final Report with the DHSSPS to inform progress, implementation and any development of the Strategy for Maternity Services.

APPENDIX ONE – ESTABLISHED STEERING GROUP MEMBERSHIP

Organisation	Representative	Designation
Northern Health and Social Care Trust	Mrs Eileen McEneaney (Chair from July 2016) Mrs Olive Macleod (Chair until July 2016)	Executive Director Of Nursing & Midwifery Executive Director Of Nursing & Midwifery
Public Health Agency Local Supervising Authority	Denise Boulter (Co Project Lead) Dr Catherine Coyle Patricia McStay	Midwife Consultant Public Health Consultant LSA Midwifery Officer
Western Health and Social Care Trust	Anne Marie McGurk	Head of Midwifery
South Eastern Health and Social Care Trust	Zoe Boreland	Head of Midwifery
Belfast Health and Social Care Trust	Brenda Kelly/ deputy Christina Menage	Head of Midwifery Lead Midwife
Northern Health and Social Care Trust	Caroline Keown	Head of Midwifery (Acting)
Southern Health and Social Care Trust	Joanne McGlade	Head of Midwifery (Acting)
South Eastern Health and Social Care Trust	Dr Roisin Hearty	Obstetrician
Western Health and Social Care Trust	Dr Michael Parker	Obstetrician
?British Medical Association	Dr Brian Patterson	GP
Royal College Of General Practice	Dr Grainne Doran	GP
Royal College of General Practice	Dr Shauna Fannin	GP
Queens University Belfast	Gail Anderson	Head of Midwifery Education
Clinical Education Centre	Fiona Bradley	Senior Education Manager
Department Health Social Services Public Safety	Verena Wallace	Midwifery Officer
Health Social Care Board	Shirley Tang	Project Manager - A Strategy for Maternity Care NI
NCT/Maternity Services Liaison Committee Representative	Seana Talbot	President of NCT/ Chair of MSLC and Council member of Patient and Client Council
Public Health Agency	Christine Armstrong	10.000 Voices Initiative
Public Health Agency	Mary Rafferty	Health Visitor
Royal College of Midwifery	Breedagh Hughes	Director RCM NI
NI Practice Education Council for Nursing and Midwifery	Karen Murray Co – project lead from December 2016 Brenda Devine Co - Project Lead until July 2016	Senior Professional Officer

Administrative Support: Mrs Linda Woods (NIPEC)

Terms of Reference for the Steering Group are as follows:

TOR1 To agree phase two of project plan, timescales and methodology
TOR2 To contribute to the achievement of the project aims and objectives
TOR3 To undertake on-going monitoring of the project against the planned activity
TOR4 To receive progress reports from the Project Leads and agree actions arising
TOR5 To contribute to the final report for submission to the PHA
TOR6 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project
TOR7 To approve appropriate communiqués for wider dissemination

- Membership of Steering Group is non-transferrable other than in exceptional circumstances and with prior agreement of the Chair.
- The Steering Group will meet on approximately every two months within during the project

APPENDIX TWO

ESTABISHED WORKING GROUP MEMBERSHIP

Organisation	**Representative**	**Designation**
Public Health Agency	Denise Boulter	Midwife Consultant
NI Practice and Education Council	Karen Murray (from Dec 2016) Brenda Devine (until July 2016)	Senior Professional Officer
Northern Health and Social Care Trust	Shona Hamilton	Consultant Midwife
		GP representative
		Sure start representative
	Caroline Wallace	Maternity Support Worker
		La Leche representative
Reps from Maternity Service Liaison Committees	Seana Talbot	SHSCT MSLC
Western Health and Social Care Trust	Amanda Sayers	Lead Community Midwife
Northern Health and Social Services Trust	Bid Mc Keown Martina Doolan	Lead Community Midwife Lead Community Midwife
Belfast Health and Social Care Trust	Mary McCormick	Practice Development Midwife
Southern Health and Social Care Trust	Patricia Kingsnorth Frances Biggerstaff	Midwife Midwife
South Eastern Health and Social Care Trust	Melanie Fitzpatrick Paula McConn	Midwife Midwife

Terms of Reference for **Working Group** are as follows:

TOR1 To keep within timescales and methodology of the project
TOR2 To contribute to the achievement of the project aims and objectives
TOR3 To report progress/ challenges of the project to the Steering Group against the planned activities
TOR4 To contribute to the final report for submission to the PHA
TOR5 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project
TOR6 To contribute to communiqués for wider dissemination

- Membership of Working Group is non-transferrable other than in exceptional circumstances and with prior agreement of the Chair of Working Group
- The Working Group will meet on approximately four/six weekly within during the project
- Chair of the Working Group will rotate between Co-Project Leads (agreed)

APPENDIX THREE – (SUGGESTED) WORK PLAN

Work Plan JANUARY 2016 – MARCH 2017			
Activity		Target	Related Objective
1	Close down phase one of the project	Jan / Feb 2016	All
2	Agree project plan and work programme for phase two	Feb 2016	All
3	Conduct literature reviews to determine: I. Current patterns of postnatal care from delivery to 6 week postnatal visit and discharge II. National and International normative range of caseload per whole time equivalent midwife in the community setting (rural and urban) with the possible input of care from the maternity support worker	March 2016	All
4	a) Develop and agree a communication strategy to include referral patterns and the interfaces between midwives, health visitors, general practitioners, obstetricians and others b) Review Engagement Report and the QUB Maternity Experiences Report identify gaps and agree if necessary methods of capturing information on current provision of postnatal care - Design and agree questions if necessary c) Review and analysis data collated	July 2017	All
5	a) Develop proposals of models of postnatal care at will achieve:- 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. And objective 22 - Women will be advised and encouraged to attend their six week postnatal appointment with the appropriate clinicians b) Agree the essential supporting resources required to provide postnatal maternity care in the community settings c) Communicate service developments to the wider public.	October 2017	All

APPENDIX FOUR - EQUALITY AND GOVERNANCE SCREENING

Area	Comments
Risk Management questions	
• Have any risks been identified? • What is the potential impact of these? • How can these be mitigated or have alternatives options been identified which would have a lower risk outcome? • Where negative impacts are unavoidable, has clarity been given to the business need that justifies them?	
Equality and Human Rights questions	
• What is the likely impact on equality of opportunity for those affected by this policy for each of the Section 75 equality categories (minor/major/none)? • Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories? • To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group (minor/major/none)? • Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group? **NB –** please refer to NIPEC's Equality Screening Policy and Screening Templates to assist in considering equality and human rights	
Privacy Impact Assessment (PIA) questions	
• Will the project use personal information and/or pose genuine risks to the privacy of the individual? • Will the project result in a change of law, the use of new and intrusive technology or the use of private or sensitive information, originally collected for a limited purpose, to be reused in a new and unexpected way?	
Personal and Public Involvement (PPI) questions	
• Has a requirement for PPI been identified, and if so, what level of PPI will be required for the project? **NB –** please refer to and use NIPEC's PPI Decision Tree/Algorithm to assist in considering PPI	

For further Information, please contact

NIPEC
Centre House
79 Chichester Street
BELFAST, BT1 4JE

Tel: 028 9023 8152
Fax: 028 9033 3298

Website: www.nipec.hscni.net

January 2017