The Regulation and Quality Improvement Authority

Review of A Strategy for Maternity Care in Northern Ireland (2012-18)

March 2017

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at **www.rqia.org.uk**.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

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Executive Summary

In 2010, the Department of Health Social Services and Public Safety, known as the Department of Health (DoH) from May 2016, carried out a review of policy on maternity service provision in Northern Ireland. The review focused on the best available evidence for the care and treatment of mothers-to-be; quality, safety and service sustainability; wider workforce issues; and professional roles and responsibilities. Subsequently, A Strategy for Maternity Care in Northern Ireland 2012-2018 was published on 2 July 2012. The Strategy provides an outcomes focused approach to maternity care. It sets out six desired outcomes which are underpinned by 22 objectives.

RQIA has carried out this thematic review to consider progress made in relation to taking forward the goals and objectives of the strategy, since its publication.

HSC trusts advised RQIA that they welcomed the strategy as it contributed to more collaborative working to raise standards in maternity care. RQIA found strong support for the strategy as it was generally perceived to be a very positive development for the future delivery of maternity services.

A significant amount of work has already been undertaken by the Maternity Strategy Implementation Group (MSIG) and sub groups, to address the objectives and six outcomes.

The review team found evidence of strongly committed leaders and teams and regional structures set up with many committees and sub groups to support the work being carried out. There was also evidence of multi-disciplinary working involving various stakeholder partnerships.

RQIA considers that there have been significant achievements in relation to the first outcome of the strategy. These include both regional public health programmes and local initiatives. Major challenges remain in tackling inequalities in health, both in particular groups in society and also in particular areas of high deprivation. With regard to preconceptual care, while recognising the work which is already being carried out, RQIA found that this was an outcome of the strategy where additional focus was required in the second half of the implementation period.

Some leadership challenges identified by the review team were in relation to the promotion of pathways of care during pregnancy involving the midwife and mother, support for vaginal birth as well as the need for greater inter professional relationships and mutual respect between teams.

RQIA was informed that General Practitioners (GPs) were not familiar with the maternity strategy objectives and other key stakeholders such as Northern Ireland Ambulance Service (NIAS) and service users have not been represented within MSIG. RQIA considers that there is a need for wider representation and involvement for all key stakeholders on MSIG.

Since the publication of the strategy, there has been significant progress in relation to taking forward the fourth outcome with the development of the regional Core Pathway for Antenatal Care which has been an important development in progressing the objectives relating to this outcome.
RQIA has concluded that there have been developments in taking forward the outcome relating to Safe Labour and Birth (Intrapartum) Care, but that it should remain a key area of focus for the rest of the strategic planning period.

Since publication of the strategy, there has been progress in taking forward improvements in the information available for women to assist them in making choices regarding their maternity care. There have also been developments in the provision of alongside and freestanding maternity units, but as yet, not all consultant units have an alongside midwife-led unit as recommended in the strategy. The Northern Health and Social Care Trust (Northern Trust) should put in place a MLU, to provide similar levels of care and choice for women to those in other trusts.

In relation to post natal care, there has been limited focus on the objectives relating to this outcome in the first three years of the strategic implementation period. The MSIG has advised RQIA that work on this area will be taken forward by the Community Maternity Care Group during the rest of this strategic implementation process.

Workforce issues have been highlighted in all aspects of the service particularly in relation to the heavy reliance on locum staff and retirement of midwives which will significantly impact upon the service. This report has made nineteen recommendations.

Section 1: Introduction

1.1 Development and launch of the Maternity strategy

In March 2010, RQIA published the report of its Review of Intrapartum Care[2]. It made 20 recommendations for the service across Northern Ireland.

The 2010 report noted that no specific documented maternity service strategies existed at the time of the review in any of the five trusts. The review team noted the absence of an over - arching maternity strategy at regional level. RQIA highlighted five key areas for future development:

- staffing levels
- effective clinical leadership
- protected training time
- use of information systems
- standardisation of audit processes

In 2010 the DoH carried out a review of policy on maternity service provision in Northern Ireland. The review focused on the best available evidence for the care and treatment of mothers-to-be; quality, safety and service sustainability; wider workforce issues; and professional roles and responsibilities. Subsequently, a draft maternity strategy was issued for public consultation. The consultation received a large number of responses, from a wide range of stakeholders. Following analysis of the responses to the consultation, the final strategy, A Strategy for Maternity Care in Northern Ireland 2012-2018, was published on 2 July 2012.

In launching the new strategy, the DoH indicated that there was a need to promote a culture of "normalisation" of pregnancy and birth:

"*Northern Ireland has a higher prevalence of interventions, including caesarean sections, when compared to elsewhere in the UK and...[the Republic of] Ireland. We need to know why this is the case. The recently launched Maternity Strategy proposes that trusts benchmark such interventions against comparable maternity units across the UK and [the Republic of] Ireland in order to address the cause of this disparity. Maternity care – regardless of whether it is public or private care, should be of a high standard and make the best possible use of resources*…"[3]

The maternity strategy has a six year timeframe and will continue until 2018.

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[2] http://www.rqia.org.uk/cms_resources/RQIA%20Review%20of%20Intrapartum%20Care%2011%20May%2010.pdf

[3] Oral Answer provided to NI Assembly on 11 October 2011 to Oral Question AQO 523/11-15. Cf: Report by the Comptroller and Auditor General. 29 April 2014. NI Audit Office

The aim is to "…provide high-quality, safe, sustainable and appropriate maternity services to ensure the best outcome for women and babies in Northern Ireland".

RQIA has carried out this thematic review to consider progress made in relation to taking forward the goals and objectives of the strategy, since its publication. RQIA recognises that this interim review relates to the midpoint of the lifetime of the strategy, which continues until 2018.

1.2 Structure of the Strategy

The Maternity Strategy for Northern Ireland (2012-2018) aims to provide women, professionals, policy makers and commissioners with a clear pathway for maternity services, from pre-conceptual care through to postnatal care. It places an emphasis on early direct contact with a midwife and a better understanding of the role of the midwife and obstetrician.

The Strategy provides an outcomes focused approach to maternity care. It sets out six desired outcomes which are underpinned by 22 objectives. The 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 women and babies
- appropriate advice, and support for parents and baby after birth

The 22 objectives of the strategy are set out in Appendix 1

The strategy includes performance measures related to each of the 22 objectives. The outcomes and objectives were designed to assist in the development of an Action Plan to take forward the strategy.

1.3 Implementation Arrangements

The Health and Social Care Board (HSC Board) and Public Health Agency (PHA) were appointed by the DoH to co-lead on the implementation of the strategy, working in partnership with other HSC organisations, the public and voluntary and third sector organisations. The implementation process was designed to include the following approaches:

- The HSC Board and PHA should lead on the development of an action plan to be submitted to DoH by 31 January 2013.

- The HSC Board and PHA should each nominate a lead individual to be jointly responsible for taking forward implementation and each trust should have a named individual to coordinate action within the trust.

- The DoH should receive an annual report on progress towards implementation.

- An implementation group should be established, to consider measures that demonstrate progress towards implementation of the outcomes and associated objectives.

Section 2: Background

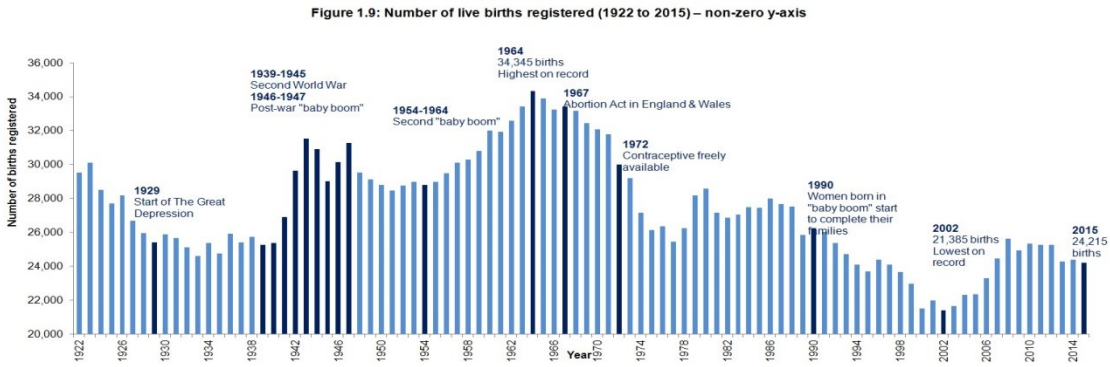
Maternity services in Northern Ireland aim to support women and to ensure the best possible start in life for their babies. This includes care from preconception advice through pregnancy, birth and the postnatal period[4]. As indicated by National Institute for Health and Care Excellence guidance (NICE), pregnancy is a normal physiological process and therefore any interventions offered should have known benefits and be acceptable to pregnant women.

2.1 Birth Trends

According to the Registrar General Annual Report 2015[5] the number of babies born in Northern Ireland has been relatively stable in recent years, varying between 24,500 and 25,500 since 2007. In 2015, there were 24,215 live births (12,493 males and 11,722 females) registered to Northern Ireland women, 179 fewer than in 2014. This equates to approximately 66 babies born every day in Northern Ireland. The report has indicated that the number of births in 2015 continues to be lower than the corresponding figure from 30 years ago when 27,427 births were registered.

The annual report has also stated that in keeping with other parts of the United Kingdom, there has been a fall in the number of babies born to women under 20 and for those in their early twenties. Births to women in their thirties have increased by almost 2,200 and the proportion of all births that were to women in their early forties has doubled. In addition, the average age of women giving birth is now 30 years of age, with associated higher rates of medical complexity. The percentage of births to mothers in Northern Ireland who were born outside the UK and Ireland reached 10 per cent for the first time in 2013 and this rate has been steadily increasing.

Figure 1: Number of live births registered -1922 to 2015[5]



[4] A Strategy for Maternity Care in Northern Ireland. 2012 – 2018. Department of Health. Northern Ireland

[5] http://www.nisra.gov.uk/archive/demography/publications/annual_reports/2015/Births.pdf

2.2 Maternity Units

The majority of women give birth in either an obstetric consultant-led unit (around 22,000) or in a Midwifery-led Unit (MLU) alongside a consultant-led unit (around 3,000). Table 1 shows the obstetric and MLUs in each HSC trust.

Births at the Royal Jubilee Maternity Hospital (RJMH) in Belfast accounted for 24% of all babies born in Northern Ireland in 2015. Births at the Ulster Hospital Dundonald and Craigavon Area Hospital each accounted for 17% of all births respectively. The number of births fell at a number of hospitals, following a change in the profile of units from obstetric consultant-led to MLUs. Births at the Mater Hospital Belfast changed from around 1,100 per annum prior to 2013, to 196 in 2015. A similar decrease in the number of babies delivered at Lagan Valley Hospital was also apparent, from around 1,100 prior to 2011 to approximately 200 in subsequent years. In contrast, there was a sharp increase in the number of babies being born at the Ulster Hospital with 4,131 births last year compared to around 3,000 babies in the years prior to 2010.

In 2015, 93 babies were born in places other than a hospital in Northern Ireland, representing an increase of 16% on the previous year. The majority of these babies (75) were born at home. Home births continue to represent a very small proportion of all births, but recent guidelines from the NICE advise that a birth in either the home or a MLU are equally safe for women who have previously given birth and who are considered to have a low risk pregnancy.[6]

Service changes have included a steady increase in the provision of MLU in Northern Ireland as well as the consolidation of models of midwifery led care e.g. caseload midwifery. The most recent MLU opened in April 2014 in Daisy Hill Hospital, with births recorded on the Northern Ireland Maternity System (NIMATS) from November 2014. This development has resulted in a change in the overall landscape of maternity care services in Northern Ireland, which is strongly supported by the regional strategy. Currently there are eight MLUs, five of which are adjacent to obstetric-led units and three which are freestanding MLUs. The Northern Trust is the only trust in Northern Ireland that does not have a MLU.

[6] National Institute for Health and Care Excellence. *Intrapartum care: care of healthy women and their babies during childbirth*. NICE guidelines CG190, 2014. http://www.nice.org.uk/guidance/CG190 (Accessed: 5 May 2015).

Table 1: Obstetric and Midwifery-led Units in each HSC trust

Trust	Trust Maternity Unit	Type of Care	Additional Information
Belfast	Mater	Midwife-Led	Changed from Consultant-led to Midwife-led unit in April 2013
	Royal Jubilee Maternity Hospital (RJMH)	Consultant Obstetrician-led	
Northern	Antrim	Consultant-led	
	Causeway	Consultant-led	
South Eastern	Downe	Midwife-Led	Opened 22 March 2010
	Lagan Valley	Midwife-Led	Changed from Consultant-led to Midwife-led unit on 2 February 2012
	Ulster	Midwife-led (Home from Home) and Consultant-led	Home from Home opened in August 2007
Southern	Craigavon	Midwife-led and Consultant-led	Midwife-led unit opened 17July 2000
	Daisy Hill	Midwife-led and Consultant-led	Midwife–led unit opened 2014.
Western	Altnagelvin	Midwife-led and Consultant-led	
	South-West Acute Hospital	Midwife-led and Consultant-led	Formerly known as Erne Hospital. Midwife-led unit opened in December 2012

The South West Acute Hospital has five rooms and two birthing pools for women who are deemed appropriate for midwife-led care. The Northern Trust had no MLU facilities but indicated that discussion was underway to explore options to develop these. However, the review team was unable to determine exactly what progress had been made. The Belfast Health and Social Care Trust (Belfast Trust) informed the review team that they plan to open a low risk facility within the RJMH facility. No timeframe to implement this change was shared with review team.

2.3 Choice of Place of Birth

While home births continue to represent a very small proportion of all births, guidelines from the NICE advise that a birth in either the home or a MLU are thought to be equally safe for women who have previously given birth and who are considered to have a low risk pregnancy[7].

Despite this evidence, and a conservative estimate by the Royal College of Obstetricians and Gynaecologists that at least 30% of women fall into the category of 'without complications'; only 13% of women are currently giving birth in England outside obstetric units, and the home birth rate is falling[8]. The conclusion is that the provision of services to allow women to choose birth outside of obstetric units remains patchy.

Figures reported for home births in Northern Ireland from 2005 to 2015 have ranged from between 67 births to 105 births per year, (less than 0.37%), with a pattern of this being further reduced[9]. There was no evidence from this review that home births were being actively promoted.

2.4 Trends in Birth Delivery Modes: Births and Method of Delivery

Reducing the number of unnecessary caesarean sections, is an important priority within the regional maternity strategy and has been referred to by the Health Minister as a way of promoting normalisation of birth. It has also been referenced as part of the outcomes relating to effective communication and high-quality maternity care, as part of the accountability for implementation of the Strategy. Northern Ireland generally has had a higher Caesarean Section rate than the rest of the United Kingdom and the Republic of Ireland[10].

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[7] Registrar General Northern Ireland Annual Report 2014 Publication date: July 2015 Registrar General. NISRA

[8] National Audit Office. Maternity services in England, HC 794 Session 2013-2014. London: The stationary office: 2013.

[9] NISRA Annual Report 2015. Home Births for 2005-15. Table 3.20

[10] Maternity Indicators Report (up to 31st March 2014). Prepared by Performance Management and Service Improvement Directorate. (PMSID) for the Maternity and Child Health Service Team. June 2015

The difference is most marked for Elective Caesarean Sections. Between 2008-2009 and 2013-2014 the percentage of caesarean sections has remained fairly constant at between 28%-30%, compared to 25-26 % in other parts of the United Kingdom. In 2013-2014, the maternity units in the Southern Health and Social Care Trust (Southern Trust) had the highest Caesarean rate in Northern Ireland with 34.5%, which was a slight increase of 0.7% on the rate in 2012/13 (33.8%). The exact reason for this is not known but a caesarean section in one pregnancy can lead to more complications in later pregnancies[8].

The proportion of assisted deliveries (13.5 %) was comparable to neighboring countries but the proportion of spontaneous vertex (normal deliveries) (56.2 %) was below the mean of 61-62 %.

Section 3: Approach to the Review

3.1 Terms of Reference

The terms of reference for this review are:

1. To assess the interim progress on the implementation of the regional strategy (2012-18).

2. To identify whether any issues have arisen that may affect the future delivery of the strategy.

3. To report on findings and make recommendations as a single report for publication.

3.2 Methodology

To inform the review, RQIA asked individual organisations to complete a template in relation to progress made against each of the 22 objectives contained in the maternity strategy. RQIA then met with the organisations to discuss these responses in greater detail. The main aspects of the review involved the following:

1. Background review of key strategic work undertaken in relation to the regional Strategy for Maternity Care (2012-2018).

2. Completion of a proforma by HSC Trusts, PHA and HSC Board to assess progress made in the implementation of the regional strategy against the 22 objectives included in regional strategy.

3. Meetings were held between 26 November and 2 December 2015 during which the RQIA review team met with multidisciplinary staff groups in each HSC trust. Meetings were also held with senior management in the HSC Board and PHA to discuss progress on the implementation of the strategy.

4. The review team met with members of the MSIG, Safety Forum and representatives from the Royal College of Obstetricians and Gynaecologists (RCOG).

5. Focus group discussions were held with each of the integrated care partnership general practitioner leads to obtain their views in relation to the maternity strategy and GP involvement in primary care.

6. A meeting was held with a Sure Start coordinator midwife who is also a member of the MSIG.

7. A survey developed by RQIA was used to obtain views of members of the MSIG and sub groups on progress made against each of the strategy objectives.

8. Feedback on the main findings of the review was presented to the Regional MSIG on 10 February 2016.

3.3 Membership of the Review Team

Leslie Marr	Senior Programme Manager (Reproductive Health) Scrutiny and Assurance, Healthcare Improvement Scotland.
Elizabeth Bannon	Co-Director, Maternity and Women's Health, Belfast Health and Social Care Trust OBE (Retired)
Dr Laura McLaughlin	ADEPT trainee, NIMDTA Clinical Fellow Obstetrician (ST7)
Dr Matthew Forbes	MRCGP, STI Obstetrics and Gynaecology Belfast Health and Social Care Trust, General Practitioner (England)
Dr David Stewart	Director of Reviews and Medical Director, RQIA
Karen McCaffrey	Project Administrator, RQIA
Mary McClean	Project Manager, RQIA

Section 4: Findings

4.0 Progress on Implementation of the Maternity Strategy (2012-18)

HSC trusts advised RQIA that they welcomed the strategy as it contributed to more collaborative working to raise standards in maternity care.

RQIA found strong support for the strategy as it was generally perceived to be a very positive development for the future delivery of maternity services.

The strategy was thought to have empowered staff, particularly midwives, as it reinforced their role. It was also considered to have provided an impetus for service improvement, enabling staff to refocus on their roles and responsibilities and providing them with an important direction of travel.

Staff across a number of HSC trusts told the review team that the strategy has highlighted the role of the midwife as the main care provider, especially for low risk pregnancies. It highlighted the need for more midwifery care in the community, with the hospital being reserved for higher risk pregnancies.

The Royal College of Midwives supported the aims of the strategy in recognising a woman's right to choose the type of care they have and their place of birth.

The strategy adopts an outcomes based approach to maternity care around six outcomes. Each outcome is underpinned by a number of objectives documented throughout the strategy. In this section, RQIA has considered the effectiveness of the arrangements put in place to implement the strategy and the progress made so far towards achieving each of the six outcomes.

The strategy contains 22 objectives for implementation over a six year period, to enable the planning and delivery of quality maternity care. The MSIG has drawn up a plan to take forward a programme of actions to achieve the objectives that includes timescales for delivery. It uses red amber and green ratings to show if actions are on track or delayed. [11].

The MSIG Action Plan for 2015-2016 is organised into the following sections:

- Reducing Risk – relating to strategy objectives 8, 9 and 13
- Normalisation of pregnancy – relating to strategy objectives 2, 6, 18 and 20.
- Antenatal Care – relating to strategy objectives 3, 4, 10, 11, 15 and 16.

[11] rating scale showing significant delay or risk (Red); some delay or risk (amber) and green (on track)

4.1 Outcome 1: Give Every Baby and Family the Best Start in Life

Pregnancy is well recognised as a normal physiological process and before this happens it is important that women are as healthy as possible, as it has been suggested that up to a half of pregnancies may be unplanned. The strategy aims to promote public health messages around factors which may adversely affect the health of women and their unborn children. The objective in relation to this outcome focuses on the promotion of public health messages for women and girls of childbearing age.

- A universal approach to major public health messages for women and girls of child bearing age will be promoted. This includes the importance of healthy lifestyles, and a focus on the social factors and clinical outcomes which are known to have an adverse impact on outcomes for mother and baby (Objective 1).

Factors which may be related to poor outcomes are:

- diabetes, obesity and poor nutrition
- teenage pregnancy, smoking, alcohol and socio-economic deprivation

and

- gender-based violence, substance misuse and poor mental health

The public health strategic framework, Making Life Better (2013-2023) highlights the need for a collaborative approach in relation to the development of universal and targeted programmes to include ante and post-natal care and parenting programmes. There are a number of programmes delivered through the DoH such as the Early Intervention Transformation Programme (EITP) which aims to improve outcomes for children and young people and which is targeted at those from more socially disadvantaged backgrounds.

Strengths

- The RQIA survey[12] circulated to MSIG and subgroup members showed that the majority of people believed that good progress has been made in relation to this objective. Comments from members of this group were that public health messages are not part of the work of the MSIG, as the public health aspects of the strategy are being led by the regional tobacco, obesity, mental health and breastfeeding groups rather than by MSIG. However, there are strong links to the MSIG. Significant work has been carried out on smoking and obesity in pregnancy. Maternal mental health is being addressed through a revised perinatal mental health pathway, which is to be updated in light of recent NICE guidance.

[12] RQIA survey circulated to all Maternity Strategy Implementation Group and subgroup members to obtain feedback on the progress being made on the implementation of each of the 22 objectives.

There is also ongoing work to advice women with specific conditions such as epilepsy and diabetes on their particular condition. In addition, options for a midwifery-led service for minority/ethnic and new immigrant women are under consideration.

- A regional report on the maternity needs of minority ethnic and migrant women has been produced by the PHA for consideration by the Department of Health.

- RQIA found a wide range of activities and programmes in a number of areas facilitated by Sure start[13], Twins and Multiple Births charity and TinyLife, the premature baby charity in Northern Ireland. The Western Health and Social Care Trust (Western Trust) has recently submitted a bid for a Family Nurse Partnership scheme to address teenage pregnancies. The trust currently has a part time teenage pregnancy midwife in the Southern Sector of the Western Trust.

- All HSC trusts are involved in a range of health initiatives to promote healthy lifestyles for women before and during pregnancy. Significant work has been carried out relating to smoking and obesity in pregnancy and the PHA has developed an initiative *Weigh to a Healthy Pregnancy* Programme to support work in this area.

- Smoking cessation advice is offered at antenatal clinics within HSC trusts. All trusts became smoke free areas from the beginning of March 2016. Smoking during pregnancy remains an issue, particularly for women from more deprived areas. The Belfast Trust has a significant percentage of pregnant women who smoke, which is currently between 20%-25%. A smoking cessation pathway has been set up with an online referral service for those wishing to attend smoking cessation clinics. The Southern Trust has the lowest rate of smoking in pregnancy across Northern Ireland at 12.9%, compared with the Northern Ireland average of 16.5%.

- Social deprivation has been found to significantly impact on health, particularly during pregnancy. Within the Belfast Trust there are high levels of deprivation with the highest levels being found in North and West Belfast[14]. Examples of issues may include drug and alcohol addiction, teenage pregnancy and mental health and domestic abuse. The trust has set up a clinic in response to local demand to address needs around teenage pregnancy, drug and alcohol addiction and social issues to support women through their pregnancy, using a dedicated midwife and social worker, with consultant obstetrician support. There is a good relationship between Sure Start coordinators and social services.

[13] UK government initiative giving children the best possible start in life through improvement of child care, early education, health and family support, with an emphasis on outreach and community development.

[14] http://www.nisra.gov.uk/deprivation/archive/Updateof2005Measures/NIMDM_2010_Report.pdf

- The EITP Work stream which is to be embedded in each trust, aims to equip all parents with the skills needed to give their child the best start in life and will focus on three key parenting stages; *Getting Ready for Baby* (laying the foundations for effective parenthood), *Getting Ready for Toddler* (developing and encouraging parenting skills) and *Getting Ready to Learn* (supporting parents as their child's first educator). One strand of this work stream is to embed the Solihull Approach[15] within the midwifery workforce and to introduce the Solihull Approach Antenatal Parenting Group: "Understanding pregnancy, labour, birth and your baby". The Solihull Approach is a United Kingdom programme which aims to increase emotional health and well-being through both practitioners and parents. It does this through provision of resources and training across the child and family workforce. The majority of health visitors in the United Kingdom are now trained in the use of this model.

- The Family Nurse Partnership is a programme offered to first time teenage parents. It offers intensive and structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two, with the aim of improving the health and wellbeing of disadvantaged families and children, and of preventing social exclusion. Teenage pregnancy is steadily declining throughout the United Kingdom, with Northern Ireland having the lowest rate on record in 2014 (10.32 per 1,000 females aged 13-19). The annual report by the Northern Ireland Statistics and Research Agency (NISRA) showed that 839 teenage girls became mothers in 2014. The programme is delivered across all HSC trusts.

- The Western, Belfast and Southern trusts have received accreditation for being "Baby Friendly" trusts. Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. Facilities implement the standards in stages over a number of years. At each stage they are externally assessed by Unicef United Kingdom. When all the stages have been passed they are accredited as Baby Friendly. Award tables are kept to let the public know how facilities are progressing.

- All HSC trusts offer breast feeding peer support groups and link workers to support women to breast feed, including women from ethnic minority groups. RQIA was told of the variation in provision of peer support for breast feeding and the need for continuity of breast feeding peer support in the local community. The Southern Trust has a local initiative involving women from the travelling community who provide breast feeding support and advice for other women within their community.

- All trusts have programmes to support the reduction of obesity in pregnant women and the PHA has developed an initiative, Weigh to a Healthy Pregnancy Programme to address this.

[15] https://www.nice.org.uk/sharedlearning/solihull-approach-parenting-group

- Work is progressing in relation to the development of perinatal mental health services which was highlighted as an issue across all of the trusts. The South Eastern Health and Social Care Trust (South Eastern Trust) has developed robust links with psychiatry services. The Belfast Trust has a small dedicated team lead by a psychiatrist providing an antenatal perinatal mental health clinic. The Southern Trust in an effort to address the reported increasing incidence of perinatal mental health problems, has streamlined the triage of booking letters to direct women with pre-existing problems to be seen by a consultant obstetrician with a specialty interest in mental health. The obstetrician works closely with a consultant psychiatrist with an interest in perinatal mental health.

- Domestic violence against pregnant women is an on- going problem being reported by trust staff. In an effort to address this, midwives will routinely ask women when attending clinics whether they have been subjected to domestic violence. Some trusts have undertaken multidisciplinary working with families at risk and staff in each trust have received training in prevention and support for women at risk of domestic violence.

Challenges

- The RQIA survey feedback indicated that the MSIG does not have specific involvement in the promotion of public health messages relating to pregnancy. This is managed by the PHA. Some respondents would like to see a more joined up approach and better collaboration, rather than focusing on individual issues. It was suggested that agreement around standardisation of approaches would assist trusts in their delivery of services and ultimately assist the woman and her family.

- Although there is a strong emphasis on Public Health within the strategy, the RQIA review team found that some trusts were more effective than others in adopting a Public Health approach to maternity services within their trust. The Southern Trust reported that they face an ongoing challenge in managing public health messages alongside the delivery of core services, while the review team found that the trust was proactive in the promotion of this work.

- It was suggested to the review team that there could be greater use made of social media campaigns by the PHA, to support staff delivering a range of health promotion initiatives, particularly in deprived areas and amongst ethnic minority groups.

- It is an ongoing challenge to ensure that health promotion programmes being delivered are evidence based and can bring about a sustainable change to improve the health outcomes for women and baby. RQIA was informed that smoking cessation programmes work for only a small number of women and that women from the poorest communities were less likely to attend antenatal classes, preferring one to one interaction.

The review team found that some trusts accommodated one to one interactions whilst others did not appear to have provision for this.

- It is recognised that there are a number of high risk groups with particular medical conditions requiring support in maternity care and it is difficult to deliver appropriate care pathways for these groups.

- Throughout all trusts, provision of perinatal mental health services is an ongoing challenge. Staff expressed frustration with the increasing difficulty in accessing mental health services for women at risk. Currently there are limited specialised mental health services for women who have been identified as high risk in relation to their mental health. This is a large and evolving challenge. Once the perinatal mental health care pathway has been updated and following the RQIA review of perinatal mental health, a sub group of MSIG should be set up to take forward this work.

- The RQIA survey of MSIG members highlighted the need to address pre-conceptual care messages in a collective way, so that women can identify with these, rather than reading stand-alone messages that potentially could lose impact. An example given was to have a combined leaflet on folic acid and pre-pregnancy weight, rather than having two separate leaflets.

- An ongoing challenge is the need to apply for funding on an annual basis for certain antenatal services e.g. Weigh Into A Healthy Pregnancy.

Recommendation 1	**Priority 2**
MSIG should take the lead in the promotion of Public Health messages for pregnant women and their families, taking account of individual circumstances e.g. socio economic deprivation, poor literacy etc. to provide direction in how to implement appropriate interventions and messages within HSC trusts that concur with the evidence. MSIG should also consider more use of regional campaigns and social media to support staff in the promotion of public health messages.	

4.2 Outcome 2: Safe, High Quality Sustainable Maternity Services

This outcome relates to the promotion of a culture of normalisation of pregnancy and birth in population planning, commissioning and provision of maternity care, reflecting the principles of the Transforming Your Care strategy. The strategy highlights that "a *change in culture is required by all relevant healthcare professionals and managers to "normalise" birth.*"

Two Objectives Relate to this Section:

- 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 (Objective 2).

- 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 (Objective 3).

This aspect of the strategy places an emphasis on normalising pregnancy so that there is an increasing number of women who have midwifery led care, as well as normalising birth as much as possible for high risk women.

Strengths

- Feedback from the RQIA MISIG survey showed that this work was progressing well.

- The regional maternity dashboard looks at birth outcomes on a monthly basis and encourages promotion of normalisation within maternity care.

- Trusts advised that they have provided a number of workshops for staff e.g. PROMPT Training (PRactical Obstetric Multi-Professional Training) in relation to working as a team to manage obstetric emergencies. [16]

- The strategy has helped with better collaborative working throughout trusts.

- The Maternity Quality Improvement Collaborative subgroup of MSIG has carried out work with all of the trusts on promoting normality, with the aim of encouraging more community led initiatives, which support the Transforming Your Care programme in maternity services.

- Trusts have encouraged their staff to normalise pregnancy by tailoring care to women's needs and engaging with them in a more meaningful way.

- There has been an emphasis on trying to promote the low risk care pathway for women with a straightforward pregnancy. Home birth is offered as a choice in some trusts.

[16] PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies

- There are a number of ways that trusts are promoting normalisation of pregnancy which include:
    - The Northern Trust has weekly review meetings about caesarean section rates to discuss individual cases.
    - The South Eastern Trust promotes use of MLUs and 40% of their bookings take place in the community.
    - The Belfast Trust has introduced two Birth Choices clinics which have reduced C-section rates from 36% to 25%. They also carry out ultrasound scans (USS) in the community and promote the use of their MLU at the Mater Hospital for low risk women, although delivery numbers are very small, indicating the need for greater promotion of this. They have also recently launched a new maternity website.
    - In the Southern Trust, a MLU has been set up in Daisy Hill Hospital. The trust is promoting community based clinics such as the consultant led clinic in Banbridge, with an increasing emphasis on moving care for low risk women out into the community.
    - The Western Trust has embedded initiatives to move care out of hospital settings into more community based settings, and reviewers concluded that their work in the community seemed to pre date the strategy. All bookings in the trust are carried out in GP practices. Low risk women follow a midwife led pathway and antenatal care is provided in the community by community staff.

- Different models are available in relation to birth choices for women to access within the Western and South Eastern trusts, such as aqua-natal, hypno-birthing and antenatal yoga and reflexology. Various aids can also be used such as birthing balls, birthing mats and women are encouraged to labour and deliver in birthing pools.

- A range of initiatives have been used to access women's views about maternity services. These include using comment cards within hospitals and an antenatal review survey. A regional survey has recently been conducted by Queen's University Belfast (QUB) asking women about all aspects of maternity services and the findings of this large scale survey have been published[17]. The conclusions from the report were that overall, women were largely positive about their experience of care. The initial comparisons between Northern Ireland and England showed that women's experiences were largely similar. However, women in Northern Ireland were less likely to report feeling involved in decision-making but were more satisfied with their postnatal care.

[17] http://www.qub.ac.uk/schools/SchoolofNursingandMidwifery/FileStore/Filetoupload,670193,en.pdf?platform=hootsuite

- Women's views have also been sought through the regional 10,000 voices project managed by the PHA who have published a report on this.[18] Women's view have also been obtained via social media and trust websites.

- RQIA was informed that a guide for women, the Pregnancy Book, has been developed. Reviewers highlighted the importance of having this information shared with the 20% of the population who have literacy difficulties. All pregnant women in Northern Ireland are provided with a free copy of the regional Pregnancy Book which is updated annually with information for women on: a healthy pregnancy; labour and childbirth; and the first week with your new baby.

- There has been an emphasis on promoting the low risk care pathway for women with an uncomplicated pregnancy. This has been supported by the development and publication in January 2016 of guidelines for admission to an MLU, by the Guidelines and Audit Implementation Network.

Challenges

- Women's co-morbidities have changed, with medical profiles becoming more complex, including increasing maternal age; obesity, IVF pregnancies and previous C-Sections. Alongside this, women's demands have changed, with the expectation and assumption that a "normal pregnancy" will almost certainly be achieved within the confines of their increasing complexity.

- The review team was informed that from a regional perspective, there is a need to ensure that normalisation does not impact on safety, e.g. low risk women who have a high risk fetus. There is also the need to ensure that women are being risk assessed when their care is being moved out into the community.

- RQIA found a lot of variation between the trusts in relation to delivery of perinatal mental health care. Some trusts such as the Belfast Trust and the South Eastern trust have made some provision while other trusts such as the Northern Trust do not have any service provision.

- Within maternity services, it was found that trusts are managing risk in their own way, with no overall standardisation of this on a regional basis. It was suggested to the review team that the issue of risk could be managed with the establishment of a Northern Ireland regional forum in the form of a maternity network.

[18] http://www.publichealth.hscni.net/sites/default/files/Annual%20report%2010000%20Voices%20%20Final%20Oct14.pdf

- Cultural issues may play a part in a woman's choice or influence whether they are genuinely informed choices. Some women prefer and expect to be managed in hospital or reviewed by a consultant obstetrician, while others actively avoid hospital care, seeking instead midwifery led care.

- The review team was informed that cultural influences have played a part in the low rate of home births.

- In the last 10 years there has been a shift in GP training with GPs having little or no obstetrics training. As part of their contract, GPs are required to provide antenatal care. However, this is rarely undertaken within General Practice unless there is a community midwife in the practice. This is further demonstrated by the lack of or inappropriate use of antenatal growth charts.

- Workforce issues have been identified across all areas of maternity services. consultant expansion in Northern Ireland did not happen to the same extent as in England, which has led to problems within the service, such as heavy reliance on locum staff. There is currently a call for 24 hour onsite labour ward consultant obstetrician cover in line with National Guidance.

- Trust staff highlighted that there is a real issue with recruitment of medical, midwifery and nursing staff into obstetrics and gynaecology across the UK. Feedback from the MSIG survey has been that there is a need to "*provide maternity services with the correct amount of staff to ensure that the hard working midwives, Doctors and auxiliary staff can deliver a safe service for women and babies*".

- New and more equipment such as appropriate ultra sound scanners which would allow increased use in community care are necessary. There are different IT systems in use and not all staff have access to all systems, which may lead to gaps in maternity records, which is a safety and governance issue. More resources are needed in the community in order to promote and sustain community led care and the culture of normalisation.

- Increasing the availability of home births in keeping with new NICE Guidance is difficult due to staffing issues and lack of community resources.

4.3 Effective Communication and High Quality Maternity Care

This aspect of Outcome 2 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 woman, her baby, partner and the wider family.

The Objectives relating to this Section are:

- A Maternity communication protocol/pathway will be developed outlining 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 (Objective 4).

- Maternity Services must show good clinical leadership and communication, including in the use of the hand-held record, Labour Ward Forum and other multi-disciplinary groups (Objective 5).

- Work will progress to agree minimum datasets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice (Objective 6).

- The NIMATS will be continually reviewed and updated to ensure it is fit for purpose to promote coordinated regional data collection, in line with data collection principles and information governance (Objective 7).

The objectives relating to this aspect of the strategy highlight 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 support which continues to develop to meet regional and local needs

RQIA found that all trusts welcomed the strategy and considered it to be a very positive development for the future delivery of maternity services. The review team met with positive caring and engaged staff who considered that the strategy had empowered staff, particularly midwives. It has provided them with more of an impetus to do things properly, as well as enabling staff to refocus on their roles and responsibilities. There was a general feeling that the strategy has provided a direction of travel and helped open up regional talks with all trusts.

However, some staff also expressed reservations about the strategy, indicating that it could have done more in the provision of choice for women.

Strengths

- Feedback from the RQIA MSIG survey showed that this work was progressing well.

- In some areas across the trusts, the review team found that the culture and leadership was very positive in terms of the promotion of a "*can do" approach.* Trusts have used innovative ways to embed the strategy into their organisation, such as the provision of MLUs. The Western trust has an innovative system of community midwives supporting midwives in the MLU and rotating staff out into the community to increase staff skill base. The Southern Trust has 20% (850) of births in Craigavon hospital occurring in the MLU, while the South Eastern Trust MLU in the Downe Hospital operates an on call system at night.

- There is a clear implementation structure, with monitoring arrangements put in place to assess progress in the implementation of the objectives.

- The MSIG group meets on a quarterly basis and is co-chaired by the PHA Director of Public Health and the Executive Director of Nursing and Allied Health Professionals. There is also representation from a wide range of stakeholders including DoH, the five trusts, Primary Care with GP representation; PHA and the HSC Board.

- Ten subgroups associated with the MSIG have been set up to contribute to programmes of action arising from the strategy[19]. These subgroups have contributed to a significant body of work to date, with representation from a wide range of stakeholders in the implementation of strategy objectives.

- The community care subgroup of MSIG has devised a plan for maternity care (2012-18) where the overarching aim is to facilitate women to make early contact with a midwife (Objective 10) and to provide antenatal care in the community to women with straightforward pregnancies (Objective 12). The plan will also focus on access to booking scans, and NIMATS in the community (Objective 11); women making informed decisions about place of birth (Objective 16) and a greater emphasis on postnatal care (Objective 21 and 22).

- As previously stated, the introduction of the strategy has helped to promote more collaborative working relationships across the trusts. There are examples of good working relationships between midwives and obstetric consultants, with regular meetings taking place.

[19] Community Maternity Care Project; NIMATS; Preconception Care; Antenatal Education; Maternity Quality Improvement Collaborative; Early Pregnancy Assessment Service project; Epilepsy in Pregnancy Project; Diabetes in pregnancy; Multiple pregnancy; Flu & Pertussis vaccination in pregnancy

The Southern, Western and Belfast Trusts have formalised multidisciplinary morning handovers. The Northern Trust has fortnightly perinatal meetings involving paediatricians, midwives and obstetric consultants.

- The strategy has helped to shift the balance to a more multidisciplinary way of working as well as promoting the role of the midwife in being more autonomous.

- There is greater emphasis on lessons learned from Significant Adverse Incidents and all trusts have a dedicated risk management team with regular meetings to discuss Significant Adverse Incidents.

- The review team was told of examples of good working relationships within each trust; e.g. within the Western Trust there is collaborative working between community and hospital staff with GPs having interface meetings with hospital staff and there is more multi-disciplinary team working during ward handovers. The trust also has a consultant mentoring system for junior medical staff.

- There are examples of good practice across trusts involving rotation of midwifery staff within units and between the community and hospital sector, thus providing a more integrated service.

- There are examples of communication tools used across all of the trusts such as the maternity hand-held record and History, Assessment, Review and Transfer tool which ensures appropriate sharing of information between professionals and departments.

- There is a regional pregnancy book that is given to all pregnant women which has recently been updated.

- Midwives in the community are able to access patient electronic care records.

- There is a Royal College of Midwives birth choices leaflet and a self-referral letter, which provide information on birth choices.

- RQIA was advised that a regional maternity dashboard has been established. The dashboard contains trust specific information, which is circulated on a quarterly basis. The dashboard is regularly reviewed, audited for trends and displayed for staff and women to view. The continuing development of the regional dashboard is being taken forward by MSIG.

- Trusts also collect information for their own maternity dashboards and review their performance against quality indicators.

RQIA reviewers were impressed by the quality improvement work being taken forward in this regard by South Eastern Trust staff who were considered to be very proactive. RQIA was advised that the quality improvement initiatives which have been taken forward through the regional collaborative have been valuable in a number of areas including: normalising childbirth; reduced fetal movement; post-partum haemorrhage; sepsis; and vaginal birth after caesarean section.

- The Strategy recommends that HSC trusts measure intervention rates and compare these with rates in the United Kingdom and the Republic of Ireland. This ensures that HSC trusts are well placed to assess the standard of maternity care provided and make best possible use of resources.

- The NIMATS is the regional information system to support the work of maternity services. It provides information at trust level and information for regional analysis of trends and statistics. NIMATS is available in both hospital and community settings. There are NIMATS managers within each trust who draw out data on a monthly basis.

- The NIMATS is currently under review, with all trusts having both clinical and ICT representatives on the steering group and working groups. The NIMATS has its own structures but is also included in the remit of the MSIG.

- The recent GAIN guidelines - NI Normal Labour and Birth Care Pathway – are viewed positively and will help to provide consistent management across Northern Ireland.

- Feedback from MSIG members is that links with the e-health team work are very positive.

During this review, RQIA identified significant strengths in the arrangements put in place to take forward implementation of the strategy, but also that challenges had emerged which may impact on its full delivery.

Challenges

- There is a need for a culture of improvement and transparency with innovative leaders, to ensure that there are good interpersonal links and interpersonal respect among disciplines.

- From a strategic perspective, the implementation of the strategy has been seen for some as an opportunity to develop maternity services, e.g. within the Western Southern and South Eastern trusts, while within other trusts there continues to be a resistance to change and a reluctance to fully embrace the strategy.

- Regionally, the review team gained an impression that communication within trust maternity services may be dependent on particular people. This may be lost when staff move or rotate out of their posts.

- Feedback from MSIG group members included the need for more regular updates on the work of each of the sub groups and for there to be improved communication between them to ensure continuity.

- Feedback from the RQIA survey in relation to the maternity hand held record included that the records were difficult to navigate and that deciphering notes could also often be difficult, with a risk that important information could be missed. Other professionals found it to be useful and did not highlight that there were any difficulties.

- A challenge for MSIG is to encourage senior obstetric medical staff's engagement in the implementation of the strategy. Challenges have also been identified around the involvement of general practitioners, who reported not being familiar with strategy objectives, which may compromise their role in the delivery of maternity care.

- The MSIG currently does not have any representation from service users/family with personal experiences of the service.

- The MSIG has no representation from the NIAS which was initially involved in the development of the strategy and has a key role in the transfer and care of pregnant women between different units or from home.

- The NIAS told RQIA that they have found a perception amongst some staff within trusts, that women requiring transfer from MLUs will receive priority status over other women. MLUs have been set up to manage the care of women with a low risk pregnancy. However, even in a low risk pregnancy, there are instances where a woman will need to be transferred to the nearest obstetric unit. The NIAS advised that all women are prioritised according to individual clinical need. The NIAS and trusts will continue to work together in relation to the further development and implementation of free standing midwife led units.

- The NIMATS for regional data collection has received mixed reactions across the trusts. In some trusts the system has proved to be useful, while others feel the data collection system could be significantly improved in terms of more updated software; specifically -
    - The system should run parallel with the pregnancy.
    - It doesn't link from one hospital to another.
    - Difficulty with inputting and extracting relevant data.
    - There is no antenatal component.
    - Other disciplines, e.g. anaesthetics, have reported that NIMATS doesn't capture relevant information for their specialty and that transfers between trusts are not recorded.

- Some professionals suggested that the insertion of the Robson classification for caesarean section criteria be included to extrapolate more precise delivery information. Proposed in 2001, the Robson classification is a system that classifies women into 10 groups, based on their obstetric characteristics (parity, previous CS, gestational age, onset of labour, fetal presentation and the number of fetuses).

The above indicates that although the service has changed, the NIMATS may need to be reviewed to ensure it is meeting the needs of health professionals working within maternity services.

- As the demands on the role and time of midwives have evolved especially in relation to the development of additional specialist midwifery roles, trusts have reported that there they are limited in what they can deliver within existing resources.

- There is currently no 24 hour midwifery cover in the community and an on call rota is required.

- Some staff thought the pregnancy and 0-5 book is too lengthy, running the risk of women missing important and relevant information.

Recommendation 2	**Priority 2**
The DoH should consider the development of a maternity network with similar levels of accountability to the neonatal network.	

Recommendation 3	**Priority 2**
MSIG should review membership of the group with a view to having more involvement of obstetricians, General Practitioners, Northern Ireland Ambulance Service, service users and community pharmacists.	

Recommendation 4	**Priority 2**
MSIG should evaluate the implementation of the new initiatives which have been taken forward in the first phase of implementation of the maternity strategy including the Core Care Pathway for Antenatal care and the Guidelines and Audit Implementation Network guidelines for admission to MLUs.	

Recommendation 5	Priority 3
MSIG should consider incorporating the Robson classification for caesarean section criteria into the NIMATS.	

Recommendation 6	Priority 2
The NIMATS review should ensure that the system is meeting the needs of health professionals working within maternity services.	

Recommendation 7	Priority 1
HSC organisations, including NIAS, should review the transfer arrangements for women between freestanding midwife-led units and consultant-led units.	

4.4 Outcome 3: Healthier Women at the Start of Pregnancy (Preconception Care)

This outcome relates to any advice given or management that occurs before a pregnancy. Two objectives were included relating to this aspect of care:

- 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 8).

- A clear pathway of care will be available for individuals with long term conditions who are planning a pregnancy and throughout the pregnancy (Objective 9).

Strengths

- Feedback from the RQIA MSIG survey was that some progress was being made.

- Within the community some community midwives provide pre conceptual care. Some trusts have a strong community midwife/GP infrastructure which provides opportunities to include pre conceptual care during contact with women.

- The MSIG has established a pre-conceptual care group to take forward actions in relation to the strategy objectives for this outcome.

- An initial area of focus for the group, was to develop proposals to increase the uptake of appropriate levels of folic acid by women at the critical time for it to be effective, namely in the three months prior to conception and in the first three months of pregnancy. The sub group has developed guidelines on the use of folic acid and appropriate dosages for each woman. The group has also carried out a survey on the use and understanding of folic acid and vitamin D for pregnant women.

- Sure Start midwives and family planning nurses may be in an ideal position to address pre conceptual care.

- Within the Belfast Trust, the fetal medicine department provides pre-pregnancy counselling for women with high risk pre-existing medical conditions referred to them. As the regional tertiary centre, the Belfast Trust provides neurology, cardiac, haematology and fetal medicine clinics which accept antenatal referrals from all trusts.

- RQIA was advised that in all trusts there is a dedicated clinic for women with diabetes, both pre-existing and gestational, where specialist consultants and nurses work in collaboration with obstetricians and midwives to manage their preconceptual care.

Challenges

- The review team heard examples of a fragmented and inconsistent provision of pre conceptual care, with uncertainty as to who has responsibility for ensuring women with well documented pre-existing medical conditions have access to a service.

- Pre-conceptual care is carried out on an ad hoc basis with no dedicated pathway and a strong reliance on good will.

- In relation to pre-conceptual care, some have the view that the strategy has been too ambitious and covers too wide an area.

- There is a reliance on Primary Care to provide pre- pregnancy counselling to both high and low risk women.

- There is no community pharmacy representation within MSIG. Although there is some recognition of community pharmacy being well placed to provide advice to women on pre-conceptual care, specifically in the use of folic acid, there has been no development of this role.

- There is a lack of good pre-conceptual care for women with cardiac disease and autoimmune conditions. The pre-pregnancy counselling offered within the fetal medicine department in the Belfast Trust is limited, with demand being greater than the availability.

- Currently there is no accountability for pre-conceptual care and a lack of collaborative multi-agency /multidisciplinary working.

- There is a strong need for a coordinated regional approach in relation to pre-conceptual care.

Recommendation 8	**Priority 2**
A pathway for pre conceptual care should be developed by the Maternity Strategy Implementation group, to include pre conceptual care for women with specific medical conditions such as cardiac disease and autoimmune conditions.	

Recommendation 9	**Priority 2**
MSIG should review the role of Primary care in relation to provision of pre-pregnancy counselling to both high and low risk women.	

Recommendation 10	**Priority 3**
The MSIG should explore ways to make better use of community pharmacy links in relation to providing information and advice on good pre conceptual care to women of child bearing age.	

4.5 Outcome 4: Effective Locally Accessible Antenatal Care and a Positive Experience for Prospective Parents - Antenatal Care

Antenatal services cover all the care for a woman from when she discovers she is pregnant until she goes into labour. This outcome of the strategy covers six Objectives:

- When a women becomes pregnant she will be facilitated to make early direct contact with a midwife (Objective 10).

- There will be appropriate access to booking scans and the NIMATS in the community and non-acute hospital settings (Objective 11).

- For women with straightforward pregnancies, antenatal care will be provided primarily by the midwife in the local community (Objective 12).

- Women with complex obstetric conditions will have care led by a consultant obstetrician (Objective 13).

- Women will be encouraged to contact their midwife if a problem develops, to ensure only women who require the care of an obstetrician are referred to the Maternity Assessment Unit. (Objective 14).

- 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 (Objective 15).

These relate to women being facilitated to make early direct contact with a midwife and thereafter when required, as well as having access to booking scans in the community and non-acute settings. They should also have access to obstetric care where required and to antenatal education.

Findings from the published survey on women's experiences of maternity services showed that midwives were the health professional most commonly seen by pregnant women, with 89% seeing a midwife one or more times antenatal. Half (52%) saw an obstetrician at antenatal checks.

The survey showed evidence of limited continuity in antenatal care, with 23% of women seeing the same midwife every time and a third seeing just one or two midwives over the course of their pregnancy. However, 31% saw five or more different midwives.

Strengths

- Feedback from the RQIA MSIG survey was that work is progressing well in relation to antenatal care objectives. However, reviewers noted that 52% of women see a consultant obstetrician.

- At the time of writing, there was an ongoing regional review of imaging services. One strand of the imaging review is considering the needs of maternity services and the outcome of this work is awaited.

- The Core Pathway for Antenatal Care (May 2016) was specifically developed to support women with straightforward pregnancies and for care to be provided primarily by the midwife in the local community. It sets out the roles and responsibilities of staff and the key aspects of care which are important to consider at each antenatal visit. It was considered that an improved infrastructure was necessary to support the work undertaken by community midwives. There is increasing pressure within community midwifery teams. This is as a result of a change in the patterns of care delivery with the demand to see many more antenatal women in the community and a significant decrease in length of postnatal stay. Additionally, there is no 24 hour midwifery cover in the community and home births are covered using an on call system. Some community staff reported that due to time constraints it was difficult to embed public health messages as part of their routine antenatal care visits, although the review team found that this was being routinely carried out by Western Trust staff.

- Currently, there is access in the community in most trusts to USS and the NIMATS. NIMATS is available in GP practices and is used for the booking appointment by the midwife. Community midwives are also able to access the patient electronic care records.

- Booking USS for low risk women is carried out by midwives in a number of areas in the community. The midwives are required to have completed a USS course. One suggestion for improvement related to midwives and health visitors accessing a community information system - PARIS, which is available in some trusts, so that community midwives and health visitors have access to a woman's history.

- A community indicators group is currently developing key activity indicators in order to better measure the workload of community midwives.

- RQIA was told that all women have a named community midwife and contact details are provided to them for advice or questions. The contact information is recorded in the Maternity Hand Held Record and includes telephone numbers for antenatal appointments, admission and assessments units, antenatal clinics and parent craft education. Low risk midwifery led clinics are available in a variety of settings including maternity units, GP surgeries and community settings.

- The pathway includes the role of GPs and health visitors as partners in maternity care and emphasises the role of the maternity hand-held record, as key in the communication process. It is still in the development stages having been tested by midwives and is awaiting review by GPs.

- Examples of good antenatal practice include :
    - In the Western Trust, midwives perform a risk assessment at booking. Women who are considered at higher risk may be offered shared care or obstetric consultant led care.
    - In the Western Trust the rotation of hospital midwifery staff with community midwives has helped to integrate the service. The trust has supported Sure Start midwives to undertake home visits.
    - In the Southern Trust, antenatal clinics for low risk women have been moved to community settings which has facilitated the midwife to be the first point of contact and enabled all women to have a named midwife. The trust has established a new day obstetric unit where women can be reviewed, managed and discharged accordingly and has specific antenatal slots on a Friday for late bookers.
    - The Belfast Trust has established a complex pregnancy clinic with dedicated social services input and interpreting services. Staff have received training for female genital mutilation recognition.
    - The Northern Trust has indicated that provision of antenatal education is a limited service at present within the trust. However, a DVD had been developed in previous years for service users outlining pain relief options.
    - The South Eastern Trust is reviewing its patient information and antenatal education events, to ensure these meet the needs of those who use them. It also aims to monitor this to ensure continuous improvement.

- There are birth choices clinics available in each trust led by senior midwives and lead obstetric consultants.

- Each trust has liaison midwives with good links and working relationships with social services and a range of voluntary sector providers. In the Belfast Trust there are link maternity workers who work within the travelling community.

- Risk assessment questions have been incorporated into the care pathway to ensure that women identified as being at risk are referred to obstetric led care. Risk assessments are carried out at the booking stage and documented within NIMATS. Aspects of risk assessment include women who smoke or have a history of depression. The proposed pathway needs also to be linked to the soon to be revised perinatal mental health care pathway.

- Trusts have welcomed self- referral for women to antenatal care services and a self-referral letter has been developed by the MSIG, which will soon be available on every trust website. An example of this is within the South Eastern Trust, at Lagan Valley Hospital where women can complete a form and upon receipt of this, midwives will arrange the first booking appointment and will notify the woman's GP.

- Community midwives, where available, are significantly involved in the delivery of antenatal care as well as intra natal and post natal care and are based within GP services. GPs are strongly in support of the role of community midwives. The role of the community midwife varied from trust to trust as did the relationships with GPs. All trusts employed community midwives.

- The Family Nurse Partnership scheme is well embedded across all trusts, dealing with the antenatal period and supporting both women and children up to the age of two.

- Antenatal education for women is carried out within trusts, in both hospital settings and in the community. This is regularly reviewed to develop the appropriate model of antenatal education, to prepare women for parenthood.

- Trusts participate in regional meetings with the PHA to discuss antenatal education.

- Due to the increase in women with medical complexities such as diabetes or epilepsy attending for antenatal care, clinics staffed by obstetricians, midwives supported by physicians and specialist nurses are held in each trust. This is to ensure improved communication, planning and advice on women's care pathways. Specialist clinics are also available for women with multiple pregnancies.

- All trusts have access to interpreting services for women who don't have English as their first language.

- There is an ongoing regional imaging review, one strand of which is looking at maternity services. Recommendations will be made as to how scanning services should be delivered.

Challenges

- GPs are responsible for the medical care of women throughout their pregnancy. However, they may not actually review the patient antenatally and it was noted that most no longer routinely completed the women's antenatal customised growth chart. There is a need for greater clarity, in relation to expectations of staff within the service as to whether this function will be performed by GPs in the future.

- The Review team considered that the MSIG should work with trusts to develop a regional imaging policy about when women should be scanned and this should be available to view on a regional system so that women who transfer care do not need re-scanned. There was also a view that standards should be developed about staff who are competent to scan as currently there are no guidelines available in relation to what competencies are required, particularly for doctors.

- NIMATS is available largely in the community but there is very limited access to ultrasound scanning in the community and in most areas booking scans are still carried out by obstetricians or radiographers. Most women still have to attend a maternity unit for their dating scan. In the near future, health visitors will have access to NIMATS booking reports via the electronic care record.

- RQIA was informed that there is a regional lack of ultra-sonographers who can perform more specialist scanning.

- Currently, scans cannot be shared or accessed across the region due to the lack of electronic infrastructure to support this. The service is awaiting the outcome of the Imaging Review.

- Improved scanning equipment and resources in community settings are needed so that funding streams are directed more at midwives as front line providers of care.

- Antenatal care in the community is provided by midwives; however the delivery of this care is very variable across trusts. It was considered that more innovative ways could be used to deliver the pathway, such as providing care within the community setting rather than in hospital clinics.

- In more rural trust areas such as the Southern Trust, women had difficulties in accessing transport to attend certain hospital appointments, leading to very considerable expense.

- The Southern Trust made reference to the needs of migrant women, e.g. the East Timor community and the challenge of ensuring that they are able to engage with services.

- RQIA was told that there were different scanning practices and approaches used throughout the region to promote greater use of community bookings. Some trusts perform the dating scan before 10 weeks gestation. Others book women in the community in order to promote community bookings and then perform the dating scan by 13 weeks within the hospital setting. In some areas, resources are not available to provide scans in the community and therefore these are carried out in hospital clinics.

- Regionally, there is no bespoke service for women who book late, even if noted to be high risk, although some trusts such as the Southern Trust have made their own arrangements to accommodate “late bookers”.

- Feedback from some professionals has been that due to time constraints, it has been difficult to discuss public health messages as part of routine antenatal care visits.

- Currently there are no specialised mental health services for women who have been identified as high risk in relation to their mental health, although there is some provision within the Belfast Trust. This is a large and evolving challenge and one which the MSIG should be aiming to address through the revised perinatal mental health care pathway review.

- Currently there are informal links to psychology services but no formal strategy or programmes of care for women within trusts.

- There is wide variation in the antenatal education being provided across the region. There is a need for provision of effective antenatal education within the community, to better prepare women for pregnancy, labour, birth and parenthood.

Recommendation 11	**Priority 2**
There should be a review by the MSIG regarding the role of the GP in provision of antenatal care, specifically in the use of customised growth charts.	

Recommendation 12	**Priority 3**
The MSIG should work with trusts to develop a regional USS protocol for antenatal care. This should include standards and competencies that are required of practitioners. Data from scans should be available for audit and quality assurance.	

4.6 Outcome 5: Safe Labour and Birth (Intrapartum) Care with Improved Experiences for Mothers and Babies

Intrapartum care is the care and support provided for a woman in labour. This outcome covers five objectives within the strategy relating to:

- 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 (Objective 16).

- 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 (Objective 17).

- 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 (Objective 18).

- Freestanding midwife-led units will be considered as an option for the provision of accessible, high-quality, sustainable, and effective maternity care (Objective 19).

- 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 (Objective 20).

The review team acknowledged the increasing complexity around some labours and the issues this presents for trusts. The Belfast Trust as a regional unit has indicated that they provide 30% of maternity care to other trusts and highlighted the gap between women's requests and expectations and the actual provision of care that the service could deliver.

The survey findings by QUB on women's experiences in maternity services reported that more than half of the caesarean sections (53%) were planned and carried out before the woman went into labour, while 8% were planned but carried out after labour started and 39% were the result of unforeseen problems during labour. The vast majority of women (98%) gave birth in hospital, within either a midwife led (40%), or obstetric consultant-led unit (58%). Only a small minority (1%) gave birth in a midwife-led unit separate from hospital or at home (0.4%), the majority of whom had planned for a home birth.

Strengths

- Feedback from MSIG members was that work was progressing well in relation to these objectives.

- At their booking, women are provided with information on the options of where to give birth. Women are offered the full range of services within their local trust, however at any time in the pregnancy they may choose to transfer their care to other trusts or to another form of care e.g. midwife led to obstetric led or vice versa.

- The review team was informed that each woman's options for birth are discussed with her, highlighting any risk factors and including the possibility that care choice may have to change from low to high risk. As part of the risk assessment, History, Assessment, Review and Transfer forms are used to communicate information when transferring care from midwifery-led to obstetric consultant-led and vice versa.

- Midwife-led units are provided on the same site as each consultant- led unit in the Western, South Eastern and Southern Trusts.
  In the Southern Trust, an alongside midwife-led unit was opened in November 2014. In the South Eastern Trust, the unit at Lagan Valley Hospital became a freestanding midwife-led unit in February 2012.

- Since the strategy was published, freestanding midwife-led units have been established at the Mater and Lagan Valley Hospitals in addition to the unit which was already in place at the Downe Hospital.

- There is an increased emphasis on midwifery led care for "low risk" births.
    - The Belfast Trust can triage women of low risk to the Mater MLU. There is a DVD which shows the service and delivery rooms, which all have birthing pools in situ. The trust indicted it has plans to develop an additional MLU.
    - The Downe and Lagan Valley hospital MLUs are being evaluated to help inform this process.
    - The South Eastern Trust has recently put in place a birthing pool.
    - The Southern Trust has established an MLU at Daisy Hill Hospital and the Western Trust has an MLU in Enniskillen at the site of the South West Acute hospital. The Southern Trust has worked to increase their vaginal delivery rate and thus reduce their C-section rate. This is supported by the right women coming in at the right time for induction of labour. The trust has a vaginal birth after a caesarean working group with the aim of establishing a Birth Choices Clinic.

- The MSIG has taken forward the development of the regional maternity dashboard which provides information about intervention rates. As indicated above in relation to Objective 7, RQIA was advised that the addition of Robson Groups to NIMATS would be helpful and would facilitate comparison between units.

- Trusts are examining the reasons for higher intervention rates and taking actions to address this as highlighted under Objective 2, which relates to the promotion of a culture of normalisation of pregnancy and birth.

- All trusts provide support mechanisms for women who have suffered stillbirth or neonatal death, with links to SANDS and Tiny Life voluntary organisations. SANDS in Northern Ireland are working with the trusts to provide advice about the upgrade of their bereavement rooms for families who experience a stillbirth.
    - All trusts have memory boxes, a book of remembrance and an annual remembrance service.
    - All trusts have a bereavement coordinator.
    - The Belfast Trust has counselling rooms and a clinical psychology group for women who have been bereaved, as well as a bereavement forum.

- In the Northern Trust there is a bereavement support group in Causeway. The trust has asked women who have not had a positive experience to make suggestions to improve the service.
- Within the South Eastern Trust the Ulster hospital has a bereavement suite.
- The Southern Trust plans to provide a bereavement suite in Craigavon Area hospital.
- The Western Trust is working with SANDS to create a bereavement room and has midwives who have undertaken bereavement training.

Challenges

- The Northern Trust has yet to establish a MLU in line with other trusts. The trust advised it was exploring possible options to establish alongside MLUs but definite plans had not been established.

- In the Belfast Trust whilst midwife led care is available across all areas, there is not a midwife-led unit alongside the obstetric consultant-led unit in RJMH. The trust advised that there are plans to establish a MLU.

- The Mater Hospital became a midwife-led unit in April 2013. The Belfast Trust continues to provide the regional centre for maternity services for the most complex cases.

- The home birth rate in Northern Ireland is lower than the overall United Kingdom average.

- Currently, there can be difficulty in retrieving and returning the maternity record for women, e.g. for women who have transferred to and/or given birth in another trust.

- RQIA found that there has been limited work so far in taking forward the concept of a more formal network approach to the provision of care across organisational boundaries, as set out in this objective.

- There are challenges within the system in transferring women from MLUs to obstetric units within agreed timeframes. The ambulance trust has indicated that there is a challenge in relation to staff knowledge and perception of transfers by NIAS from MLUs to obstetric units in the case of emergencies. The Belfast Trust has indicated that women have to be transferred if they change from a low risk to a high risk status and that this may affect 1/3 of women. Reviewers highlighted that if the midwife thinks it is an emergency it should be treated as such. NIAS has indicated there is a need for HSC trusts to work more closely with them in relation to the future development of midwife-led units.

- The profile of the local and migrant population of Northern Ireland is changing and becoming more complex, with maternity services having to adapt to these changes. Some trust areas, such as the Southern Trust which has the largest BME group have had more issues than others in relation to changing populations.
  There is a challenge around the sustainability of smaller obstetric units and how these are going to be staffed in the future.

- Patterns of available services have been found to differ across the region e.g. in relation to anaesthetic cover, where the South Eastern Trust highlighted that 75% of women coming through their labour ward have contact with an anaesthetist. It was reported that although there is now an increased consultant presence on site, in some units there are still significant issues in accessing anaesthetic cover for out of hours.

- Since the implementation of the strategy, women's co-morbidities have changed and their medical profile has become more complex, therefore requiring more complex care. For example, maternal obesity for women with very high body mass index (>40) requires special services to be put in place by trusts. Other complex areas include an increase in gestational diabetes throughout all trusts, placing an increased burden and demand on staff and resources.

- The review team was informed by staff that there has been an ongoing reluctance by GPs to refer women to the MLU at the Mater hospital within the Belfast Trust. This is in contradiction to the ethos of the strategy which says that it is imperative that women are given genuine informed choice. This means that the place of birth should be the choice of the woman and not that of the GP. Greater clarity is therefore required on the referrals being made by GPs to MLUs and consensus between trusts and GPs on their roles and responsibilities.

Recommendation 13	**Priority 1**
HSC trusts to review their on-site consultant obstetrician and anaesthetic cover in labour wards.	

Recommendation 14	**Priority 1**
The MSIG in collaboration with HSC trusts to provide greater clarity around the role of GPs in relation to informed choice for women and their referral to MLUs	

Recommendation 15	Priority 3
HSC organisations should develop plans to ensure that all obstetric consultant-led units which do not have alongside midwife-led units at present, have these in place by 2018 to meet this objective of the maternity strategy. The Northern Trust should make provision for a MLU for women with a low risk pregnancy.	

4.7 Outcome 6: Appropriate Advice and Support for Parents and Baby after Birth

The postnatal period begins with the birth of the baby and continues in hospital and then through transfer to the community. There are two objectives associated with this aspect of care:

- 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 (Objective 21).

- Women should be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician(s) (Objective 22).

The QUB survey of women's experiences of maternity services showed that the average length of postnatal hospital stay for all women was 2.1 days; 1.6 days for vaginal birth, 2.2 for instrumental births and 3.1 days for women who had a caesarean section. Women's views varied about their length of stay: for 74% this was 'about right', for some (14%) it was 'too short' and others (8%) it was 'too long'.

Strengths

- Midwives carry out new born baby checks and can discharge/transfer low risk women from the labour suite to the care of the community midwife.

- Women have access to community midwifery services for up to 28 days and can access breast-feeding peer-support workers and breast-feeding support groups and voluntary sector expertise such as the National Childbirth Trust in each trust area. All support telephone numbers are given out early with advice on when to seek help.

- The Northern Trust advised that they measure length of stay as one of the quality indicators for maternity services and this is tailored specifically to women's needs.

- The review team was informed that there is currently a drive to "up skill" maternity support workers in postnatal care, allowing them to work

alongside midwives. The Southern Trust was the first to introduce maternity support workers, which has impacted significantly on the skill mix and ratio of registered to unregistered staff. Currently there are 31 maternity support workers trained with a further five due to complete training. The Belfast Trust has two maternity support workers working in community settings while the Western Trust has six maternity support workers working in postnatal and community settings. The review team indicated that it would be of value for MSIG to evaluate women's perceptions of the care which maternity support workers deliver in comparison to registered staff.

- Women using maternity services participated in a regional survey about their level of satisfaction with maternity services including postnatal care, and the results of this have been found to be positive. Some women are also given a satisfaction survey on discharge within some trusts to complete, which is returned confidentially at ward level or by post.

- All Northern Ireland maternity units are now Unicef Baby Friendly accredited.

- Women are advised on transfer of care from the community midwife to the health visitor, to attend their GP for their six weeks' appointment. Within some trusts, for example, the Belfast Trust, some postnatal review clinics have been introduced for high risk women.

- Many of the trusts operate flexible visiting times. In some trusts such as the South Eastern Trust home from home unit partners are able to stay over to support women.

Challenges

- There is a need for community midwives to be sufficiently supported, in order to be able to deliver effective and safe community post-natal care. Access to community midwifery care varies significantly across NI, and has recently been presented as an inequality issue.

- There is an ever increasing pressure being placed on the post-natal service for early discharge of women from hospital. This may be suitable for some low-risk women; however, in some cases early discharges have resulted in readmissions of new born babies needing treatment in a neonatal unit. The Northern Trust measures length of stay as one of their quality indicators and has made this period longer compared to other trusts, tailoring it specifically to women's needs.

- RQIA was informed that since the reduction in the length of postnatal stay there has been an increase in the number of new born babies referred back into hospital for admission onto paediatric units. There has also been some variability in the measurement of this within trusts. The Western Trust has indicated that all readmissions are recorded.

- RQIA was advised that, in some instances, postnatal checks for women at higher risk were not being routinely reviewed by an obstetrician.

- The review team found that there is increasing pressure being placed on the post-natal service for early discharge of women from hospital.

- Women's transfer home can be negatively affected and delayed due to problems with obtaining timely discharge letters.

  This may be due to a number of factors, including lack of communication, waiting for prescriptions to be issued from pharmacy and midwives being unable to prescribe certain medication.

- The trusts have ongoing workforce issues, with many midwives nearing retirement age and the newly-qualified or junior midwives taking their place having limited experience. This is further compounded by the shortage of junior doctors and a heavy reliance on locum staff. There is also a need for more midwives to perform new born discharges, which requires training and resources.

There has been limited focus on the objectives relating to this outcome in the first three years of the strategic implementation period. The MSIG has advised RQIA that work on this area will be taken forward by the Community Maternity Care Group during the remainder of this strategic implementation process.

From discussion with staff, RQIA concluded that it would be useful to audit the number of women and babies admitted to hospital in the 28 days post-delivery and the reasons for readmission; also it would be useful to qualify the arrangements which are in place for facilitation of readmission and whether this is to the most appropriate unit when required.

Recommendation 16	**Priority 2**
The MSIG should review with all HSC trusts the provision of postnatal care and provision of support for community midwives in relation to this.	

Recommendation 17	**Priority 3**
The MSIG in conjunction with the HSCB should review the maternity workforce profile, particularly in relation to midwives nearing retirement and the use of locum staff.	

Recommendation 18	Priority 2
The MSIG in conjunction with all HSC trusts should review their discharge arrangements for women who have had a baby. The MSIG in conjunction with the Department of Health should put in place a system to monitor the re-admission rate of babies under 28 days.	

Recommendation 19	Priority 3
The MSIG should work with HSC trusts to develop a system to ensure that women's hand held records can be returned to their own HSC trust records department after the postnatal period.	

4.8 Stakeholder Views

4.8.1 General Practitioners

Members of the review team met with the Integrated Care Partnership GP leads from each trust to determine their awareness of the strategy. Review team members were informed by GPs that they are inherently linked with the strategy as part of their overall responsibility for the medical care of women during their pregnancy. However, they were not familiar with the objectives or outcomes of the strategy, nor did they feel that they needed to have any formal association or input into these aspects. It was felt that due to their ever increasing workload and demands on time it was very difficult for them to become familiar with any strategies being issued. GPs highlighted the effectiveness of maternity services and that there was good support for the work of midwives.

Most GP practices have an attached community midwife who works once a week and it was generally felt that GPs were happy to accept the greater emphasis on midwifery-led care. GPs indicated that due to the increase in patient demand and workload it was becoming increasingly difficult for them to carry out any maternity care.

It was felt by GPs that they are in the best place to know a women's medical history. It was also important to take into consideration that community midwives are not independent prescribers; they do not administer all vaccinations, nor are they sufficiently skilled to deal with all difficulties that may arise in relation to a pregnancy. However, midwives will refer women to maternity services and not to the GP should they detect a deviation from normal.

It was also felt there could be a greater role for community pharmacists in providing information and advice around pre-conceptual and antenatal care, e.g. in the use of folic acid.

The extent of involvement of GPs was found to vary significantly across the trusts. Some GPs are very keen to maintain as much involvement as they can with women during their pregnancy, while others see it as no longer part of their role. It was found that GPs in more rural areas, particularly within the Western Trust were much more involved with women during pregnancy.

4.8.2 Stakeholder Views Reported through the RQIA Survey

Feedback from the RQIA survey of the MSIG is that the experiences that women have could be improved and that there is still a lot to do. One view was that "*users need to continue to be involved in a collective way to ensure that all voices are heard*". Other views were:

- Information about the strategy should be fed to maternity user meetings.
- A social media group recently set up – Northern Ireland Maternity Forum, could be useful in accessing women of child bearing age in addition to Maternity Service Liaison Committee[20].
- There was the view that "women need to be involved – it cannot be a token gesture or merely a tick box if maternity care is to reflect the needs of women".
- The culture and practice within maternity services will need to move a long way to get to where the strategy needs to be in relation to its implementation. This was considered to be in relation to the lack of choice for women in having no guidelines for home births and in women being actively discouraged by some GPS from using a MLU within the Belfast Trust at the Mater Hospital.
- The MSIG needs to be able to provide more regular updates to keep all subgroups informed of progress being made and to encourage better communication between subgroups.

There were areas highlighted to be addressed for the remainder of the project. These were:

- to address education/communication to ensure that the ethos of the strategy is at the heart of everything that is being done
- to ensure that key information is being passed between professionals; use of the Maternity hand held record needs to be assessed

[20] The purpose of the Services Liaison Committee (MSLC) is to ensure that commissioners of maternity services listens to, and takes account of, the views and experiences of both users and providers of the service. The committee discusses how local maternity services could be improved and developed.

- service users need to continue to be involved in a collective way, to ensure that all voices are heard and that information about the strategy is communicated to maternity user meetings

A particular view expressed was that the project appeared a little disjointed. It was felt that it is imperative that maternity care in NI has a clear ethos. Feedback from the QUB questionnaire survey on the needs of women should also be incorporated into any actions. Finally, there is a necessity to ensure that appropriate staffing levels are available and being utilised effectively, in order to deliver a safe and high quality service for women, babies and their families.

Other challenges seen in relation to achieving the strategy objectives were that maternity education/ care needs an identity. Information needs to be easily accessible to everyone and tailored towards individual learning styles (videos and printable information as opposed to lengthy documents). Having an online platform would potentially help deliver and achieve this.

4.8.3 Survey into Women's Experiences of Maternity Services

Researchers at the School of Nursing and Midwifery, QUB have conducted the first comprehensive survey into women's experiences of maternity services in Northern Ireland. QUB was working in partnership with the National Perinatal Epidemiology Unit at the University of Oxford and the NISRA.

Their aim was to get a better understanding of the maternity services that were working well and where services could be enhanced. The overall findings of the study have been made available to help plan and improve maternity services in Northern Ireland.

Service user views have been accessed from a number of sources which include a report commissioned and funded by the HSCB and the PHA, with participation from the all of the HSC trusts.

Between November 2013 and October 2014 a total of 577 stories were collected through the 10,000 voices project, in relation to midwifery care. The analysis of the information in the report was that there was a high level of satisfaction with the standard of care.

"I feel I have received great care and understanding from the midwifery/nursing team. With this being my first baby, they were always on hand to give advice, support and care in a friendly and encouraging way".

"However I have been less impressed with some of the breast feeding support. Some midwives are excellent at this. In other cases the advice has been contradictory*, patronising and in some cases worse than no advice at all. I feel I should have been given more support by staff with the feeding."*

Another recent report was undertaken by the PHA on Stakeholder Engagement, led by the Community Maternity Services Project. The plan from this group was to take forward six key objectives identified within the regional strategy. A significant programme of engagement was undertaken to gather the views of women and key professionals about services.

The report provides information from an online survey undertaken between June and September 2014, with responses provided by women, midwives, obstetricians and GPs. 1,130 women responded to the online survey. The majority of these had their baby in the Belfast Trust, however there was representation from each of the other trusts.

The survey included many positive comments from women as well as a number of concerns:

- not being given a choice about maternity care
- lack of information about the pathway of care assigned to women
- a lack of communication in general
- difficulties for women in being able to contact their midwife
- information about antenatal classes etc. not being relayed
- a lack of consistency in women's maternity care
- appointments being too short and/or rushed
- long waiting times were also mentioned as areas for improvement

A quarter of comments relating to staff attitudes were positive, with many women stating they received excellent support from their health professionals and felt well cared for throughout their maternity care.

In relation to service improvements, feedback from women indicated that

- Most women said that greater/easier access to a midwife would progress the recommendation concerning the midwife as the first point of contact in pregnancy.
- Raising awareness through advertising/promotion in GP surgeries and online.
- Providing women with more information.
- Asking GPs to advise women to book an appointment with their midwife.

Most women said their booking was carried out within their local community and that they were given a choice about where their antenatal check-ups would take place, but the majority of women stated that they were *not* given a choice about which health professional would lead their care. Over half of women saw an Obstetrician for appointments during their pregnancy.

The most common reason for women seeing an Obstetrician was medical history, and the second most common reason was fetal growth problems, followed by routine antenatal care. Diabetes and having a previous caesarean section were also cited.

As part of the work carried out by the community subgroup of MSIG a survey of GPs was carried out.

The survey findings showed that:

- The majority of GP practices provide antenatal care led by a Community Midwife.

- Most GPs do not have an agreed referral letter to midwifery services or to the chosen maternity hospital.

- GPs routinely document antenatal checks or other pregnancy-related information in the Regional Hand Held Maternity Records but they do not routinely complete the woman's antenatal customised growth chart at each antenatal appointment from 28 weeks.

- GPs have not had training in completing Antenatal Customised Growth Charts.

- Most GPs give advice on lifestyle issues such as folic acid, vitamin D, smoking or alcohol on the first visit.

- GPs are supportive of the idea that midwives take a leading role in maternity care from the outset and consider the community midwife to be the lead professional in providing maternity care to women with a straightforward pregnancy.

- Most GPs offer women a postnatal appointment and feel that the postnatal appointment is useful. A substantial majority felt that they should provide the postnatal appointment in order to prescribe contraception as midwives are unable to prescribe it.

- The vast majority of GPs have not read *'A Strategy for Maternity Care in Northern Ireland, 2012–2018'* and are not aware of its objectives.

Section 5: Conclusions and Recommendations

5.1 Conclusion

The maternity strategy has been well received by HSC trusts and recognised as an important document in promoting the role of midwifery led care. However, there is a view that maternity services have moved on significantly since the development of the strategy, becoming ever more complex and that this has made the objectives difficult to implement, specifically in relation to what is considered the "normalisation" of pregnancy.

A significant amount of work has already been undertaken by the MSIG and sub groups, to address the objectives and six outcomes.

The review team found evidence of strongly committed leaders and teams and regional structures set up with many committees and sub groups to support the work being carried out. There was also evidence of multi-disciplinary working involving various stakeholder partnerships.

The culture of HSC Trusts was considered to be a determinant in the progression of the strategy outcomes and associated objectives. The review team found that each trust is making progress with much work still to be accomplished. The review team was impressed that a number of staff embraced a "*can do attitude*". Related to this was how some trusts were able to move more easily from acute to community based models of care.

Some leadership challenges identified by the review team were in relation to the promotion of pathways of care during pregnancy involving the midwife and mother, support for vaginal birth as well as the need for greater inter professional relationships and mutual respect between teams.

RQIA was informed that GPs were not familiar with the maternity strategy objectives and other key stakeholders such as NIAS and service users have not been represented within MSIG. RQIA considers that there is a need for wider representation and involvement for all key stakeholders on MSIG.

RQIA considers that there have been significant achievements in relation to the first outcome of the strategy. These include both regional public health programmes and local initiatives. There are differences in approach which can reflect local needs and priorities and some important initiatives such as Family Nurse Partnerships which are now available in all trusts. Major challenges remain in tackling inequalities in health both in particular groups in society and also in particular areas of high deprivation. The challenge identified by the review team in relation to this was for trusts to ensure that programmes being developed are evidence based. Care pathways should also be available to reach more high risk groups as well as more vulnerable groups.

With regard to preconceptual care, while recognising the work which is already being carried out, RQIA found that this was an outcome of the strategy where additional focus was required in the second half of the implementation period. Areas for future development include the development of a wider range of agreed care pathways for women with medical conditions, such as cardiac disease who are planning a pregnancy.

The potential for taking wider multi-sector and multi-professional approaches to the delivery of agreed preconceptual advice messages could be usefully explored.

Since the publication of the strategy, there has been significant progress in relation to taking forward the fourth outcome: effective, locally accessible, antenatal care and a positive experience for prospective parents. The development of the regional Core Pathway for Antenatal Care has been an important development in progressing the objectives relating to this outcome.

RQIA has concluded that there have been developments in taking forward the outcome relating to Safe Labour and Birth (Intrapartum) Care, but that it should remain a key area of focus for the rest of the strategic planning period. A recent report published by QUB[21] relating to maternity services, found that there were some aspects of care which had been seen as areas of concern for some time. The areas of concern included the fact that the caesarean section rates in Northern Ireland remained high and that just over half of all these were planned and carried out before labour.

Since publication of the strategy, there has been progress in taking forward improvements in the information available for women to assist them in making choices regarding their maternity care.

There have been developments in the provision of alongside and freestanding maternity units, but as yet, not all consultant units have an alongside midwife-led unit as recommended in the strategy. The Northern Trust should put in place a MLU, to provide similar levels of care and choice for women to those in other trusts.

A regional maternity dashboard has been developed which provides information about intervention rates but there is no formal system for benchmarking with comparable units outside Northern Ireland.

There is a need to review the transfer arrangements for women between freestanding midwife-led units and consultant-led units, involving NIAS in this process.

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[21] BIRTH NI: A survey of women's experience of maternity care in Northern Ireland. Fiona Alderdice, Karen Hamilton, Jenny McNeill, Fiona Lynn, Rhonda; Curran & Maggie Redshaw. First published May 2016. School of Nursing and Midwifery. Queen's University of Belfast.

In relation to post natal care, there has been limited focus on the objectives relating to this outcome in the first three years of the strategic implementation period. The MSIG has advised RQIA that work on this area will be taken forward by the Community Maternity Care Group during the rest of this strategic implementation process.

From discussion with staff, RQIA concluded that it would be useful to carry out an assessment of the number of women and babies who are admitted to hospital in the 28 days after delivery and the reasons why. Arrangements in place for facilitation of admission to the most appropriate unit when required should also be assessed.

Workforce issues have been highlighted in all aspects of the service particularly in relation to the heavy reliance on locum staff and retirement of midwives which will significantly impact upon the service.

IT systems have been found to affect some areas within the maternity services; for example the NIMATS has received mixed reviews in that some trusts found this system meets their needs while other trusts and disciplines found that NIMATS lags behind modern day IT systems, believing it to be not fit for purpose.

In conclusion, the RQIA review team found evidence of good progress being made in relation to the implementation of the strategy, and supports the work being carried out by trusts and the MSIG towards achieving the 22 objectives. However, there is still a long way to go before it can be considered to be fully implemented.

5.2 Summary of Recommendations

Recommendation 1	**Priority 2**
MSIG should take the lead in the promotion of Public Health messages for pregnant women and their families, taking account of individual circumstances e.g. socio economic deprivation, poor literacy etc. to provide direction in how to implement appropriate interventions and messages within HSC trusts that concur with the evidence. MSIG should also consider more use of regional campaigns and social media to support staff in the promotion of public health messages.	

Recommendation 2	**Priority 2**
The DoH should consider the development of a maternity network with similar levels of accountability to the neonatal network.	

Recommendation 3	Priority 2
MSIG should review membership of the group with a view to having more involvement of obstetricians, General Practitioners, Northern Ireland Ambulance Service, service users and community pharmacists.	

Recommendation 4	Priority 2
MSIG should evaluate the implementation of the new initiatives which have been taken forward in the first phase of implementation of the maternity strategy including the Core Care Pathway for Antenatal care and the Guidelines and Audit Implementation Network guidelines for admission to MLUs.	

Recommendation 5	Priority 3
MSIG should consider incorporating the Robson classification for caesarean section criteria into the NIMATS.	

Recommendation 6	Priority 2
The NIMATS review should ensure that the system is meeting the needs of health professionals working within maternity services.	

Recommendation 7	Priority 1
HSC organisations, including NIAS, should review the transfer arrangements for women between freestanding midwife-led units and consultant-led units.	

Recommendation 8	Priority 2
A pathway for pre conceptual care should be developed by the Maternity Strategy Implementation group, to include pre conceptual care for women with specific medical conditions such as cardiac disease and autoimmune conditions.	

Recommendation 9	Priority 2
MSIG should review the role of Primary care in relation to provision of pre-pregnancy counselling to both high and low risk women.	

Recommendation 10	Priority 3
The MSIG should explore ways to make better use of community pharmacy links in relation to providing information and advice on good pre conceptual care to women of child bearing age.	

Recommendation 11	Priority 2
There should be a review by the MSIG regarding the role of the GP in provision of antenatal care, specifically in the use of customised growth charts.	

Recommendation 12	Priority 3
The MSIG should work with trusts to develop a regional USS protocol for antenatal care. This should include standards and competencies that are required of practitioners. Data from scans should be available for audit and quality assurance.	

Recommendation 13	Priority 1
HSC trusts to review their on-site consultant obstetrician and anaesthetic cover in labour wards.	

Recommendation 14	Priority 1
The MSIG in collaboration with HSC trusts to provide greater clarity around the role of GPs in relation to informed choice for women and their referral to MLUs	

Recommendation 15	Priority 3
HSC organisations should develop plans to ensure that all obstetric consultant-led units which do not have alongside midwife-led units at present, have these in place by 2018 to meet this objective of the maternity strategy. The Northern Trust should make provision for a MLU for women with a low risk pregnancy.	

Recommendation 16	Priority 2
The MSIG should review with all HSC trusts the provision of postnatal care and provision of support for community midwives in relation to this.	

Recommendation 17	Priority 3
The MSIG in conjunction with the HSCB should review the maternity workforce profile, particularly in relation to midwives nearing retirement and the use of locum staff.	

Recommendation 18	Priority 2
The MSIG in conjunction with all HSC trusts should review their discharge arrangements for women who have had a baby. The MSIG in conjunction with the Department of Health should put in place a system to monitor the re-admission rate of babies under 28 days.	

Recommendation 19	Priority 3
The MSIG should work with HSC trusts to develop a system to ensure that women's hand held records can be returned to their own HSC trust records department after the postnatal period.	

Section 6: Appendices

6.1 Appendix One: Maternity Strategy Objectives

Maternity Strategy Outcome	Maternity Strategy Objectives
Give every Baby and Family the best start in life **Chapter one**	A universal approach to major public health messages for women and girls of child bearing age will be promoted. This includes the importance of healthy lifestyles, and a focus on the social factors and clinical outcomes which are known to have an adverse impact on outcomes for mother and baby.
Safe, high quality sustainable Maternity Services **Chapter two**	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.
	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.
Effective communication and high quality Maternity care **Chapter three**	A Maternity communication protocol/pathway will be developed outlining 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.
	Maternity Services must show good clinical leadership and communication, including in the use of the hand-held record, Labour Ward Forum and other multi-disciplinary groups.
	Work will progress to agree minimum datasets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.
	The NIMATS will be continually reviewed and updated to ensure it is fit for purpose to promote coordinated regional data collection, in line with data collection principles and information governance.

Pre-Conception Care **Chapter four**	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.
	A clear pathway of care will be available for individuals with long term conditions who are planning a pregnancy and throughout the pregnancy.
Effective locally accessible Antenatal care and positive experience for prospective Parents **Chapter five**	When a women becomes pregnant she will be facilitated to make early direct contact with a midwife.
	There will be appropriate access to booking scans and the NIMATS in the community and non-acute hospital settings.
	For women with straightforward pregnancies, antenatal care will be provided primarily by the midwife in the local community.
	Women with complex obstetric conditions will have care led by a consultant obstetrician.
	Women will be encouraged to contact their midwife if a problem develops, to ensure only women who require the care of an obstetrician are referred to the Maternity Assessment Unit.
	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.
Safe Labour and Intrapartum Care with Improved Experiences for Mothers and Babies **Chapter six**	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.
	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.
	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.

	Freestanding midwife-led units will be considered as an option for the provision of accessible, high-quality, sustainable, and effective maternity care.
	Inappropriate variation in practice will be reduced by examining all intervention rates, and benchmarking against comparable units across Northern Ireland, the rest of the United Kingdom and the Republic of Ireland.
Appropriate Advice and Support for all Parents and Babies After Birth **Chapter seven**	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.
	Women should be advised and encouraged to attend their six-week postnatal appointment with the appropriate clinician(s).

6.2 Appendix 2: Maternity Strategy Implementation Group Sub Groups

6.3 Appendix 3: Glossary

Belfast Trust	Belfast Health and Social Care Trust
DoH	Department of Health
EITP	Early Intervention Transformation Programme
GP	General Practitioner
HSC	Health and Social Care
HSC Board	Health and Social Care Board
Hypnobirthing	this is a birth education programme for pregnant women which teaches self-hypnosis, relaxation and breathing techniques for labour and birth
MSIG	Maternity Strategy Implementation Group
MLU	Midwifery-led Unit
NIAS	Northern Ireland Ambulance Service
NICE	National Institute for Health and Care Excellence
NIMATS	Northern Ireland Maternity System
NISRA	Northern Ireland Statistics and Research Agency
Northern Trust	Northern Health and Social Care Trust
PHA	Public Health Agency
Perinatal	Relating to the period around the birth
RJMH	Royal Jubilee Maternity Hospital
Robson Groups	the Robson Ten Group Classification System provides a means of comparing caesarean section rates in various locations
RQIA	Regulation and Quality Improvement Authority
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
USS	ultrasound scans
Western Trust	Western Health and Social Care Trust

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of The "Safeguards in Place for Children And Vulnerable Adults in Mental Health and Learning Disability Hospitals" in HSC Trust	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
A Report on the Inspection of the Care Pathways of a Select Group of Young People who Met the Criteria for Secure Accommodation in Northern Ireland	March 2011
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase One	March 2011
Review of Child Protection Arrangements in Northern Ireland	July 2011

Review	Published
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase Two	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
A Baseline Assessment and Review of Community Services for Children with a Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014

Review	Published
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of the HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
RQIA Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory in Northern Ireland	February 2016
An Independent Review of the Northern Ireland Ambulance Service	March 2016
RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	June 2016
Review of Quality Improvement Systems and Processes	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016
RQIA Review of the Operation of Health and Social Care Whistleblowing Arrangements	September 2016
RQIA Review of Adult Learning Disability Community Services Phase II	October 2016
RQIA Review of Perinatal Mental Health Services in Northern Ireland	January 2017
RQIA Review of Governance Arrangements in HSC Organisations that Support Professional Regulation	January 2017
RQIA Review of the Regional Emergency Social Work Service	January 2017

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews