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An Roinn Sláinte
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Enabling Safe Quality Midwifery Services and Care in Northern Ireland

Summary

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SUMMARY OF THE REPORT

Background

This report is an examination of midwifery and the wider maternity care and services across NI. It arose firstly from a Coroner's inquest into a baby's death, with concerns about safety in a Freestanding MLU. [1] Several other reports concerning the safety of services for women and babies both regionally and nationally [2-4] required consideration of the wider health services context of midwifery and maternity care and services.

The aim of the work was to identify the key conditions for safe, quality midwifery and wider maternity services in all settings in NI, to ensure that safe, equitable, respectful, compassionate, and evidence-informed midwifery care is available for all women and newborn infants, wherever and whenever care takes place.

The Northern Ireland context

Socioeconomic deprivation in NI is a significant factor in the health and wellbeing of the population and NI has the highest proportion of the population living in the most deprived quintile of the United Kingdom (UK). [5] There is a legacy of political instability with adverse impact on funding of public services including the health service. There has been no regional maternity strategy in place since 2018.

All NI rates for stillbirths, perinatal and neonatal deaths exceed the UK average. [6] The complexity of maternity care is affected by increasing rates of poverty [4] and of conditions including obesity and diabetes. Induction of labour and caesarean birth rates in NI have increased rapidly in the past decade and are still rising; more than 38% of women now have their labour induced, and more than 40% have a caesarean birth. [7] While similar to other UK countries and the Republic of Ireland, these rates are out of step with similar countries internationally.

Nearly all of the approximately 20,200 babies born annually are born in hospital across the five HSC Trusts. All Freestanding MLUs are currently closed; a small number of babies are born in the five small Alongside MLUs and at home. There are longstanding workforce shortages, especially of midwives.

Methods

The work was conducted in six inter-related stages between May 2023 and June 2024 (Figure 1). A whole-system and evidence-informed approach was taken to examine the underlying causes of problems, to learn from both negative and positive examples of care and services, and to identify evidence-based solutions. The methods were designed to ensure the involvement and participation of women and families, advocacy groups and charities, midwives and midwifery students, and interdisciplinary professional colleagues throughout. The perspectives of managers, leaders, and senior decision-makers working in service provision and in the organisations responsible for service commissioning and governance were also sought. Colleagues with clinical, public health, education, and research experience and expertise from across NI, the rest of the UK, and internationally, supported the work through input to the work of the Expert and Advisory Groups.

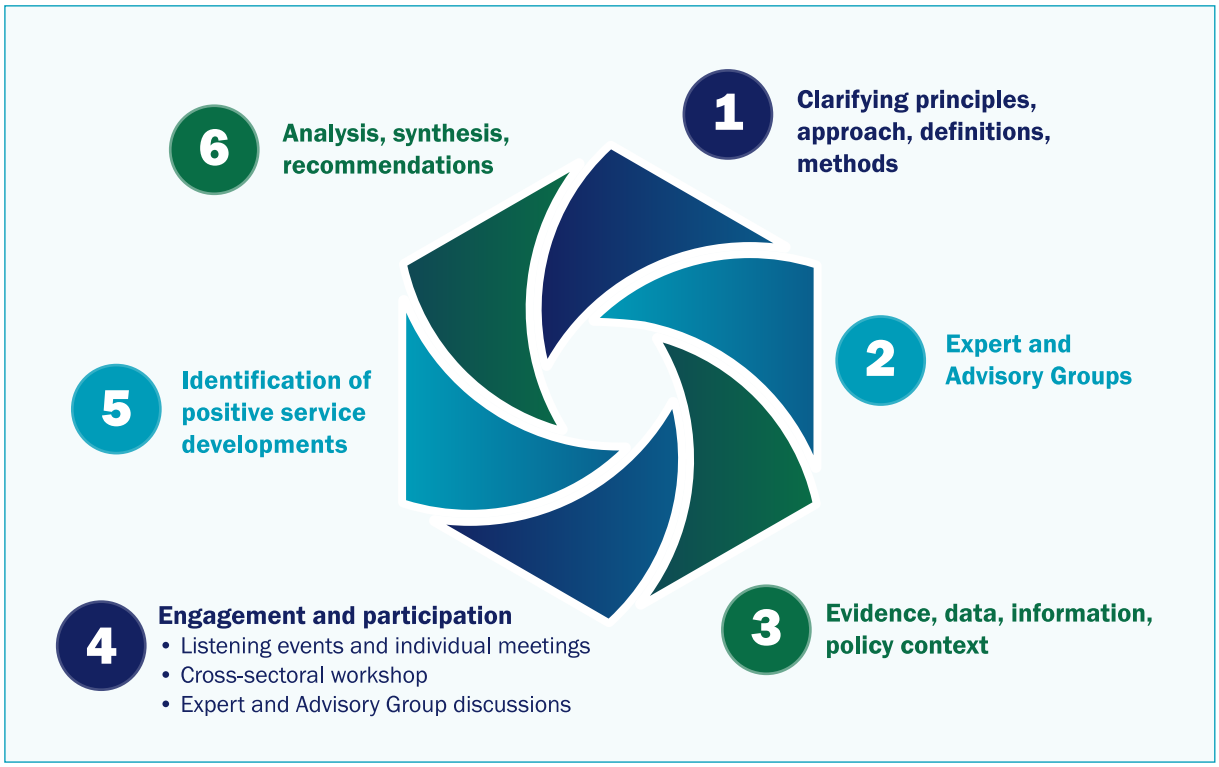

Figure 1: the six inter-related stages of the Independent Report

- We heard directly from 107 individuals including women with recent experience of the maternity services and their partners and representatives of advocacy and community groups; 159 midwifery staff including midwives, midwifery students and educators, maternity support workers (MSWs), midwifery managers and leaders; 30 interdisciplinary colleagues including obstetricians, paramedics, neonatologists/paediatricians, and General Practitioners (GPs); and 80 participants in a cross-sectoral workshop including service users, representatives of advocacy and community groups, students, and interdisciplinary professionals, educators, researchers, managers, and decision-makers. 34 meetings were held with senior decision-makers and representatives of health and social care agencies, commissioners, and Royal Colleges.
- Eight rapid efficient evidence reviews were conducted.
- Fifteen positive examples of midwifery services have been used to identify characteristics of successful services; 11 from across NI, one each from Scotland, England, Wales, and Spain.
- Responses to questionnaires were received from all Heads of Midwifery, all HSC Trust Boards, and service and education commissioners.

The widespread engagement and participation proved to be both feasible and immensely valuable, resulting in detailed information about current care and services and informing practical solutions. The recognition of the need for change, and the willingness to be involved in improving the system, was palpable.

A systematic analysis was conducted to draw together and learn from all of the findings. Two evidence-based frameworks were used to identify the essential components of safe, quality maternal and newborn care [8] and the key conditions the health system needs to ensure are in place to support safe, quality care and services [derived from Mattison et al [9] Appendix 5b]. Examination of these components informed an evidence-informed diagnosis of the underlying causes of the problems. This analysis identified strengths and gaps in current care and service provision, and identification of the evidence base for the recommendations.

What we found

Women and staff repeatedly reported that women are not consistently receiving the quality of care they need and expect in pregnancy, labour and birth, and postpartum. Some women and partners described disrespectful and damaging interaction with staff. There are deficits in care across the maternity journey, most notably in information and education for women in pregnancy, care in late pregnancy/early labour, postnatal care, and safe options for care in labour and birth outside of labour ward. These factors and the resultant inequities in care provision contributed to serious adverse outcomes and trauma for some, and pain and distress for many more.

Midwives and the wider interdisciplinary team are working in conditions where they cannot consistently give the quality of care that they know is needed and that they want to provide, and their concerns are not always heard. Services are fragmented and there is a disconnect between hospital and community services and a core focus on treating problems, not on prevention and support. The high rates of induction of labour and caesarean birth in the context of significant workforce pressures are leading to an increasingly task-focussed service and a culture that is negatively affecting both women and staff. Midwives are not able to practise the full scope of midwifery care or consistently provide the individualised care and continuity of care and carer which women told us they value and need.

There is insufficient interdisciplinary support for midwives caring for women in labour in midwifery units and at home, especially women who wish options for care 'outside of guidance'. These factors are resulting in inadequate care for some women and babies, stress and moral distress for many staff, experienced staff choosing to leave, and students and newly qualified staff not getting the experience they need. Many reported that such working conditions are not sustainable.

At the same time it is important to recognise that many women experience good quality care provided by midwives and the wider interdisciplinary team despite the challenging working conditions. There are examples of excellent, positive and innovative service provision across NI, though these were not reliably supported by the system. Characteristics of positive services have been identified (Section 5.3) and can be used to help to turn best practice into common practice. There are talented and committed staff in clinical practice, management, and education. Work is being put in place to improve safety, and there is a strong evidence base to guide the development and transformation of services.

What are the barriers?

Northern Ireland does not have all the necessary structures and processes in place to effectively drive equitable, region-wide improvement in care and services. Inequalities in care and outcomes and inconsistent processes are apparent across the region. A framework for effective interdisciplinary education and training is lacking. As a result there is inconsistent and fragmented service delivery, staff working in siloes, and unclear accountability. Across the maternity system there is limited scrutiny and evaluation including inadequate access to appropriate metrics and a lack of information about women's experiences of care and staff wellbeing; this may explain why some at senior levels of management and governance seemed to be unaware of the extent of the problems.

What is needed?

Responding to the Coroner's request re Freestanding midwifery led units

It is essential to meet women's needs for safe, individualised options for care and to ensure that community midwives work in a safe environment by developing safe, quality, equitable, accessible services for labour and birth outside of labour ward. Ensuring safe care and services means that no part of the maternity service should stand alone. There should be a region-wide infrastructure in which community midwifery hubs and alongside midwifery units and home births are fully supported and integrated seamlessly into the wider maternity services. Essential requirements for providing safe, quality care in these settings have been identified (Section 8.2), and a phased approach to implementation is needed with ongoing evaluation.

Key conditions for safe, quality midwifery and wider maternity care and services in all settings

Seven overarching evidence-informed key conditions for safe, quality maternity and neonatal care and services in all settings – hospital and community – and across the whole continuum of care have been identified (Figure 2: details in Section 8.2). These key conditions inter-relate, and for the whole system to function effectively, efficiently, and safely, they all need to be in place.

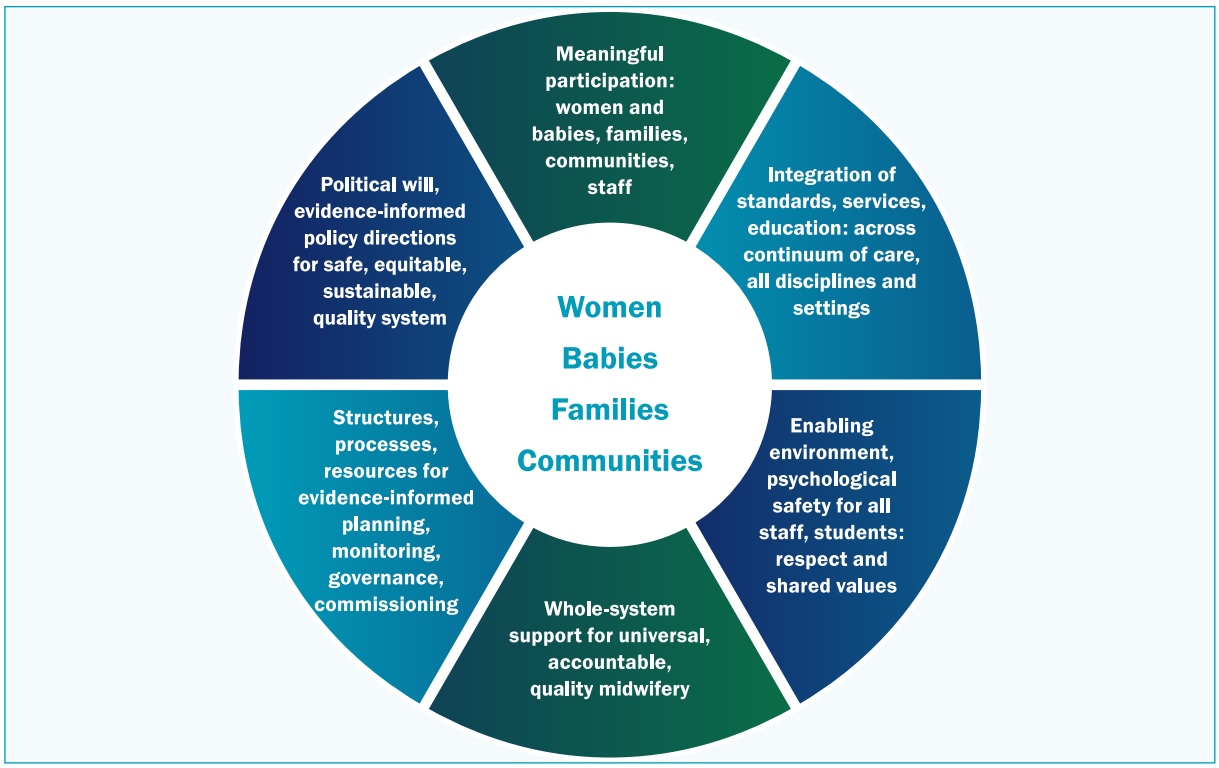

Figure 2: A quality maternal and newborn health system: key conditions for safe, equitable, quality care and services for all women, babies, and families across NI

From evidence to action - the way forward 1: recommendations for change

Thirty-two evidence-informed recommendations for action have been identified (Section 8.3.6), with operational details for each, and consideration of the organisations and groups accountable and responsible for implementation. These recommendations address the system-level issues that must be addressed to enable safe, equitable, quality care and services for women, babies and families. Their implementation will ensure the key conditions are in place for all women and babies, in all settings and across the whole maternity journey, highlighting the qualities that participants identified as essential (Figure 3).

Figure 3: Implementing the key conditions for safe, quality care across in all settings, across the whole system and the whole maternity journey

In summary, the changes needed are:

- **A shared strategic vision for safe, quality midwifery and wider maternal and newborn services in NI with a regional framework for action**. A co-ordinated regional plan is urgently needed, to be fully implemented over five years, informed by evidence of what will work, and with targeted investment that reflects the level of need and the benefit that will result. It should be developed with extensive participation of women and families, advocacy groups, and interdisciplinary staff, and with strong policy and political support, building on the work of this report. *Recommendations 1, 3, 4, 5.*

- **A reconfigured relationship with women, families and communities must be at the heart of the changes**; where women consistently receive care that demonstrates the qualities that participants identified as important; respect, kindness, trust, relationship, continuity, prevention, support, and evidence; and where women, families and communities have meaningful input into the design, delivery and monitoring of services. *Recommendations 1, 2, 3, 4, 5, 6, 7, 15, 17, 18, 30.*
- **A consistent, region-wide, evidence-informed approach to planning, commissioning, standards, provision, monitoring, and review of maternity and neonatal services.** A funded interdisciplinary regional partnership with strong service user and advocacy voice is needed to lead and drive all regional work, and evidence-based regional standards are needed to inform commissioning, governance, and practice across hospital and community. *Recommendations 5, 6, 7, 8.*
- **Improving clinical, psychological, and cultural safety and equity for women, babies and families across the whole continuum of care and in all settings**: recognising the diversity of factors influencing safety, equity, and quality for all women and babies in pregnancy, labour and birth, postnatally, and in the early weeks of life. This should include access to antenatal education and individualised antenatal care, improving care in late pregnancy/early labour especially in regard to induction of labour, and critically, improved postnatal care for all women and babies. *Recommendations 2, 5, 11, 12, 14.*
- **Changing the prevailing work culture to implement an enabling environment for all staff and managers and an open learning culture at every level of the system**. Culture is fundamental to safety, and all staff must be psychologically safe and supported to provide safe, respectful, kind, evidence-informed, interdisciplinary, individualised care for all women and babies, to effectively escalate concerns when needed, and for investigations of adverse incidents to optimise learning rather than blame. *Recommendations 9, 11, 12, 14, 21, 23.*
- **Investment in community as well as hospital services, strengthening midwifery care and services across the whole continuum of maternal and newborn care, and increasing midwives' influence over the safety and quality of care and services.** This should include a phased programme to establish and sustain safe, quality community midwifery hubs and alongside midwifery units to enable women to access options for labour and birth; continuity of midwifery care; support for midwives' work with women living in challenging circumstances and those who wish care 'outside of guidance'; support for midwifery care in labour wards including physiological birth; all in the context of appropriate interdisciplinary working and with recognition of the necessity for midwives' involvement in service planning and decision-making. *Recommendations 1, 2, 5, 11, 13, 15, 16, 17, 19, 20, 22, 24, 25, 32.*

- **Better oversight through improved accountability, monitoring, evaluation, and research:** with monitoring, review, and accountability based on accessible, appropriate information and data from research and evaluation, and improved metrics on clinical, psychological, and cultural safety, including assessment of the views and experiences of women and families, and of staff. *Recommendations 11, 13, 15, 26, 27, 28, 31.*
- **A unified approach to education and training of all staff, including leadership development - especially for midwives - and capacity building for the future.** This should include support for newly qualified midwives (NQMs) to gain the quality of experience they need, and evidence-informed interdisciplinary post-registration/ postgraduate education and training at all levels, especially training for emergencies and courageous leadership development. A midwifery career pathway and opportunities for clinical academic careers for all professional groups are needed to strengthen the capability of the whole workforce. *Recommendations 9, 10, 22, 29, 31, 32.*

Priority actions

All of the Recommendations matter. Together they form a quality system to provide safe care for all women, babies and families and whole-system implementation is needed. Individual actions cannot create sustainable, equitable change. But there are three critical priorities that address immediate safety challenges:

1. Postnatal care both in hospital and at home is essential for all women and babies to support women's physical and mental health, to promote optimal infant feeding and attachment between mother and baby, and to provide additional care for women who had difficult experiences in labour and birth. Women having caesarean births have an increased need for care and support postnatally, but the high rates of caesarean birth combined with staffing shortages on postnatal wards are leaving many women vulnerable, sometimes without adequate pain relief or essential care for themselves and their babies. This is affecting the quality of care for all, aggravated by limited postnatal home visiting by midwives. *Recommendations 11, 12, 17, 23, 27, 28, 31.*
2. Improved interdisciplinary working for women requesting care 'outside of guidance', and improved safety for the midwives who care for them. Midwives providing care for women who request care 'outside of guidance' are often working in circumstances where there is inadequate staffing and little interdisciplinary support. Women need better options for such care in both community and hospital settings, and midwives need to be supported throughout by senior midwives and interdisciplinary colleagues. *Recommendations 1, 2, 11, 20.*

3. Psychological safety for all staff. This is critically important both to ensure their own health and wellbeing, and to enable them to speak out and to escalate concerns without fear, confident that their voice will be heard and acted upon. Related to this is the lack of support and voice at Executive and Board levels for several Heads of Midwifery. They play a vital role in management and leadership of the maternity services in both hospital and community and across the whole continuum of care for both women and babies. Without their direct input Boards and Executive do not have adequate information or assurance about the safety and quality of the maternity services. *Recommendations 12, 14, 15, 16, 21, 22, 23, 26, 29.*

From evidence to action - the way forward 2: a framework for transformation

There are strengths to build on. Most staff and service managers are determined and committed to providing the best quality of care. Many women, families, and advocacy groups want to engage in improving the system. There is a readiness for change and improvement in relevant regional organisations.

A regional plan to implement these recommendations should be informed by evidence of what works to improve care and services across hospital and community. This includes ensuring the meaningful participation of women, families, staff, educators, researchers, and decision-makers. Urgent changes are needed, and the system transformation that will support and sustain the necessary changes will require a framework for interdisciplinary education and a phased approach, probably over five years. It should be led by an interdisciplinary region-wide partnership and build on existing strengths. An outline plan and a logic model indicate the essential next steps (Section 8.5.1).

Why does this matter?

Safe, equitable, quality maternal and newborn care is essential for the survival, health and wellbeing of women and babies. It forms a critical foundation for long-term population health and the wellbeing of all societies. The findings of this report indicate that implementing the recommendations will result in better short, medium and long-term physical and mental health outcomes for women, better health, wellbeing and development for babies, better experiences for all, better attachment and family relationships, better health and wellbeing for staff with improved staff retention, consistent equitable care and service provision, reduced inequalities, and better value for money in the use of health service resources.

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