



The Regulation and
Quality Improvement
Authority

**RQIA Review of Governance
Arrangements in Place to Support
Safety Within Maternity Services in
Northern Ireland**

May 2023

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rgia.org.uk.

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

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Foreword

The birth of a new baby is a joyous occasion, most of all when maternity care is experienced as safe, effective and person centred by women and their families.

Recent inquiries into NHS maternity services in England have highlighted the importance of strong governance in the delivery of safe care. This is vital to ensure that services are well led, there are sufficient numbers of skilled staff available, care is provided in keeping with best practice and that there are systems for monitoring the safety and quality of care. Good governance ensures that the right care is given in the right place, by the right person, at the right time.

This Review of governance arrangements to support safety within maternity services in Northern Ireland, gives an assessment of how the delivery of maternity care in Northern Ireland is supported by Health and Social Care (HSC) systems and processes.

The RQIA Expert Review Team found that maternity staff are dedicated and committed to the delivery of safe maternity care despite the impacts of the COVID 19 pandemic

However, the review reveals a need to improve the systems and processes that enable staff to do their jobs well. It is vital that HSC Trusts improve monitoring and oversight of maternity services, improve arrangements for safe staffing, and improve the systems and pathways for delivery of maternity care.

Particular attention should be paid to the needs of women who are socially complex, ethnically diverse and those who seek care outside guidance. The systems for delivering care to these individuals must be designed to maximise positive outcomes for women and babies, whilst supporting autonomy and choice for women.

Whilst HSC Trusts must be proactive in ensuring robust governance arrangements and a safety culture within maternity services, there are crucial roles for policy makers, commissioners and regulators.

A new maternity strategy needs to be developed, taking account of changes in society and important national and regional advances. HSC maternity services need regionally agreed safety metrics, and the formation of a Maternity Network, to shape the planning, delivery and monitoring of HSC maternity services, and make them the best that they can be.

We look forward to working in partnership across the HSC and with the professional organisations, regulators and training organisations to promote improvement in maternity services.



Christine Collins

Chair MBE



Frieze Denny

Chief Executive



Executive Summary

Each year in Northern Ireland (NI), over 20,000 womenⁱ and pregnant people avail of Health and Social Care (HSC) maternity services¹. The vast majority experience good quality care and give birth to a healthy baby. Unfortunately, not all women and babies will experience a good outcome. When harm occurs, it can be devastating, leading to lifelong disability or a tragic loss for a family². Secondary to the human costs of avoidable harm, there are substantial financial implications for HSC.

At 31st March 2022, £109.2 million had been paid in relation to HSC obstetric negligence cases that were open at any stage during the financial year 2021/22ⁱⁱ; accounting for 62% of all monies paid on clinical and social negligence cases within HSC.³ Any improvement effort that is successful in enhancing safety within HSC maternity services is likely to be cost saving and achieve long-lasting benefits in health and socio-economic outcomes for women, babies and families⁴.

Improving safety within maternity services is a national priority. Despite several high-profile inquiries and investigations over the last decade, there continue to be failings within NHS maternity services. Recent investigations into East Kent (Kirkup 2022) and Shrewsbury and Telford NHS Trusts (Ockenden 2022) expose the harrowing impact of substandard maternity care and further highlight a need for improved governance, safety culture and oversight^{5,6}. The learning from these inquiries is relevant not just to the NHS Trusts that were under review, but also nationally across the UK, including HSC maternity services in Northern Ireland.

The last Maternity Strategy for Northern Ireland was published in 2012⁷. Since then, the landscape has changed considerably. There has been an increase in the medical and social complexity of the pregnant population, as well as a rise in ethnic diversity^{8,9}. HSC maternity services, like all HSC services, have experienced unprecedented pressures since the COVID-19 pandemic. Pre-existing workforce challenges have been exacerbated and service sustainability impacted as a result¹⁰. Freestanding Midwifery Led Units (MLUs) have been closed to births¹¹ and more women are seeking care outside of recommended clinical guidance¹².

In the context of national learning, amid significant HSC pressures, RQIA determined that an up to date assessment of HSC maternity services is required. This review seeks to provide assurance, identify learning and make recommendations for

ⁱ The term 'women' is used throughout this report to reflect the majority of people who use maternity services. Service users of maternity services may also include children and young people under the age of 18, and people who identify as trans-gender or non-binary.

ⁱⁱ It is important to note that this refers to the cumulative amount paid on these open cases over a number of years, and not just money paid in the 2021/22 financial year.

improvement in maternity services across Northern Ireland. The Terms of Reference were agreed with the Department of Health (DoH) in September 2022.

Aims / Objectives

The review aimed to:

- Hear the views and experiences of women who use HSC maternity services
- Assess the effectiveness of overarching HSC Trust governance processes that support the safety of maternity services
- Assess clinical governance arrangements within HSC maternity services with regard to assuring safety of care
- Assess safety culture, including psychological safety, learning culture and just culture within HSC maternity services

Methodology

The methodology and approach was designed following a scoping exercise and engagement with a range of stakeholders.

An assurance framework was developed based on national standards and recommendations to enable an evidence-based assessment of governance within HSC maternity services.

The Expert Review Team (ERT) gathered evidence to inform its assessment through a variety of methods:

- We conducted semi-structured focus groups with service user representatives, charities and advocacy groups;
- We distributed questionnaires and requested supporting information from HSC Trusts;
- We circulated an online Safety Culture survey to HSC maternity staff;
- We conducted virtual focus groups with management teams and front-line staff from across HSC Trusts; and
- We conducted site visits to HSC Trust maternity units, where we held face-to-face focus groups with management teams and front-line staff.

Findings and Recommendations

Increased clinical complexity, compounded by staffing shortages, pose considerable challenges for the delivery of HSC maternity services. The Expert Review Team (ERT) was heartened to find that, despite these challenges, there were examples of good practice and strong teamwork across HSC Trusts. They recognised and commended the dedication of all maternity services staff who work hard on a daily basis to ensure the delivery of safe, effective care to women and babies.

Robust governance systems ensure that the right care is provided by the right person, in the right place, at the right time. They effectively identify when quality and safety falls below acceptable standards, prompting HSC Trusts and system partners to take action. The ERT found that there was a need to strengthen the systems and processes that support the delivery of safe, effective care within HSC maternity services.

HSC Trust arrangements for leadership and oversight of HSC maternity services require improvement. At the time of fieldwork, no HSC Trust Board had in place a safety champion for HSC maternity services. There was also a need to embed a partnership approach to governance between midwifery and obstetrics at a senior level. Senior leaders within HSC maternity services should be facilitated to engage directly with HSC Trust Boards on a regular basis.

In some HSC Trusts there was a need to develop an approach to governance that is broader than a focus on adverse incidents. A holistic approach to assurance looks at a range of information, including service user and staff feedback, and is supported by a multidisciplinary perspective to identify safety priorities which inform staff education and quality improvement programmes. Multidisciplinary input should be facilitated by adequate time in consultant job plans and appropriate administrative support, underpinned by robust arrangements for job planning and workforce management.

We found significant challenges in the staffing of midwifery and medical rotas and, in a number of HSC Trusts, there was a lack of dedicated out of hours' anaesthetic cover. Each HSC Trust had functioning systems in place to monitor and address staffing levels. However, due to a lack of capacity in the workforce, the current arrangements to address inadequate staffing levels were found to be impacting on staff wellbeing and also financially on HSC.

During the financial year 2021 – 2022, HSC Trusts spent over seven million pounds on locum and agency shifts for HSC maternity services alone; this is a substantial sum that could be spent more efficiently by increasing the numbers of permanent staff and further developing pathways of care.

Attracting and retaining talented staff members is dependent on a supportive workplace environment. There was variation across HSC Trusts in the support

mechanisms available to maternity staff. All HSC Trusts should invest in high-quality mentorship programmes and support for staff wellbeing, along with training for managers and clinicians on psychological safety, civility and human factors. When adverse incidents occur, staff should be supported by processes that embody the principles of fairness, openness and learning. These are essential to ensure a just and learning culture, underpinning the governance systems which support patient safety and drive improvement.

During the review, we met with women and advocacy groups who provided a valuable insight into women's experiences of maternity care in Northern Ireland. Some were exceptionally complimentary of the care provided by individual clinicians. Many gave constructive feedback on how services could be improved; most expressed a preference for the basics to be done well. Women told us that they value respectful relationships with healthcare professionals, where they are treated as partners in the decision making process and are provided with unbiased information on a range of birthing options.

There is an urgent need to strengthen arrangements to support women who seek care outside of guidance, as well as ensuring there is support available for the midwives and doctors required to provide this care. The systems and pathways for scheduled and unscheduled births also require improvement. Suboptimal staffing allocation and patient flow was found to be causing delays in induction of labour and planned caesarean births in a number of units. There was also variation in the care pathways to support women with social complexity and ethnic diversity. Co-ordinated multiagency input in the postnatal period would serve to maximise long term outcomes for vulnerable women and babies.

A new maternity strategy is needed to provide a strategic direction for maternity care in the current climate. Furthermore, work should be jointly led by relevant stakeholders to agree the metrics required to monitor quality and safety within HSC maternity services; these should be meaningful and sensitive enough to alert the HSC system to concerns at an early stage. The Maternity Collaborative was highlighted as an example of good practice. However, a formal Maternity Network needs to be established in order to drive improvement across HSC maternity services in line with regional safety priorities.

Conclusion

The review makes 23 recommendations for improvement within maternity services across Northern Ireland. The learning identified is applicable to all HSC Trusts. Whilst HSC Trusts may be at differing stages of a maternity improvement journey, all HSC Trusts will benefit from work to strengthen governance systems and processes and embed a safety culture.

It is acknowledged that there are considerable financial constraints in the current systems for delivery of health and social care. It is intended that the implementation of these recommendations will support cost-effective improvements whilst seeking to maximise patient safety.

The Expert Review Team recognises that HSC Trusts cannot and should not do this alone; they must be supported by HSC system partners, policy makers, commissioners and regulators to ensure a whole system approach to improving and assuring safe maternity care for women and babies in Northern Ireland.

Section 1: Introduction

1.1 Background and Context

Safe, effective maternity care provides the foundation for positive health and socio-economic outcomes which span across the entire life course. Each year in Northern Ireland (NI), over 20,000 women and pregnant peopleⁱⁱⁱ avail of Health and Social Care (HSC) maternity services¹³. The vast majority experience good quality care and give birth to a healthy baby. Unfortunately, not all will experience a good outcome. Systems for delivery of care are not always effective at preventing harm and, when harm occurs, it can be devastating, leading to significant lifelong consequences or a tragic loss for a family¹⁴. Secondary to these human impacts, clinical negligence claims arising from adverse events that occur within maternity services have considerable financial repercussions for HSC¹⁵.

Over the last decade, there has been a change in the case-mix of the maternity population as an increasing proportion of older women and women with complex medical conditions elect to become pregnant¹⁶. This increase in medical complexity is compounded by a rise in the number of women who present with social vulnerability factors during pregnancy¹⁷. This altered case-mix profile contributes to a higher risk of adverse outcomes and poses additional challenges for the delivery of maternity services. Furthermore, maternity services, like all HSC services, have experienced unprecedented pressures since the beginning of the COVID-19 pandemic. Pre-existing midwifery and obstetric workforce issues have been further exacerbated by burn out and stress related absence, with some staff opting to retire early or to leave their employment within HSC maternity services¹⁸. The COVID-19 pandemic has also accelerated service reconfiguration as service sustainability has been significantly impacted; Northern Ireland currently has no freestanding midwifery led units (MLU's)¹⁹, restricting patients' choice at a time when more women are seeking care outside clinical guidance. In order to effectively manage risk and reduce avoidable harm, it is vital that maternity services are well led, foster a culture of safety and have robust governance systems in place to ensure the delivery of safe, effective, person-centred care.

Improving safety within maternity services is a matter of national priority. Despite several high-profile inquiries and investigations over the last decade, including the stark findings of the Morecambe Bay Investigation²⁰ which published in 2015, there continue to be failings highlighted within NHS maternity services. The Ockenden Inquiry²¹ published its report in April 2022, and the Independent Investigation into East

ⁱⁱⁱ The term 'women' is used throughout this report to reflect the majority of people who use maternity services. Service users of maternity services may also include children and young people under the age of 18, and people who identify as trans-gender or non-binary.

Kent²² Maternity Services, published its findings in October 2022. Both reports demonstrate that lessons from previous reviews have not been learned, and, by exposing the harrowing impact of substandard care on women, babies and their families, make a compelling case for a sustained government-led commitment to improve leadership, governance and safety culture within NHS maternity services. The learning is relevant, not just to the respective NHS Trusts under review, but also nationally across the UK, including HSC maternity services in Northern Ireland.

Notwithstanding the recent high-profile focus on safety within NHS maternity services, there has been no formal endorsement of national recommendations from reviews, such as the Ockenden Inquiry or East Kent Investigation, within Northern Ireland; nor has there been fulsome regional scrutiny of HSC maternity services. The last review of HSC maternity services was undertaken by RQIA in 2017²³. It was an examination of the progress in implementation of the Northern Ireland Strategy for Maternity Care 2012- 2018²⁴ and, as such, its Terms of Reference did not warrant an in-depth assessment of leadership, governance or culture.

Given the changed landscape and ongoing challenges within HSC and, in the context of the important national learning arising from reviews and inquiries, RQIA has determined that an up to date regional assessment of HSC maternity services is now required. This independent review of governance arrangements in place to support safety within maternity services aims to provide assurance, identify learning and make recommendations for improvement within maternity services across Northern Ireland. The review and its Terms of Reference were agreed with the Department of Health (DoH) in September 2022.

1.2 Terms of Reference

RQIA drafted the Terms of Reference, subsequently agreed by the Department of Health, to undertake a review of governance arrangements to support safety within HSC maternity services.

1. To assess the effectiveness of overarching HSC Trust governance processes that support the safety of maternity services provided by HSC Trusts
2. To assess the effectiveness of clinical governance processes within HSC maternity services with regard to assuring safety of care
3. To assess the safety culture through seeking the views and experiences of staff on how psychological safety, learning and just culture is supported within maternity services in HSC
4. To seek the views and experiences of service users and their families in relation to maternity services in HSC
5. To identify learning and make recommendations for improvement

This review will focus on the governance arrangements in place to support safety within Maternity Services in Northern Ireland. Accessibility, availability and quality of services will only be assessed where there is a direct impact on patient safety.

For the purposes of this review, ‘maternity services’ refer to services that provide healthcare to women and babies during pregnancy, birth and the postnatal period. This includes early pregnancy care, antenatal care, intrapartum care and postnatal care provided by HSC Trusts in hospital and community settings. These maternity services are provided by a range of professionals, which includes midwives, obstetricians, anaesthetists and neonatologists.

Exclusions

‘Maternity care’ is a broad concept and refers to care provided throughout the maternity pathway. Other professionals, such as GPs and health visitors, may also be involved in the delivery of the maternity pathway²⁵. However, for the purpose of this review, RQIA will exclude these wider aspects of ‘Maternity Care’.

RQIA will also exclude Fertility Services and Early Medical Abortion (EMA) services. Any circulars, guidance, standards, reviews and reports which arise during the course of this review, once commenced, will not be assessed but may be highlighted for future consideration.

1.3 Review Methodology

RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies, agreed by our Expert Review Team, to obtain the necessary information to inform our assessment:



- As part of the pre-review phase, we met with a wide-range of stakeholders to help inform our review methodology and approach. These stakeholders included Department of Health (DoH), Strategic Planning and Performance Group (SPPG), Public Health Agency (PHA), Maternity Collaborative, Northern Ireland Royal College of Obstetricians and Gynaecologists, Royal College of Midwives Northern Ireland, Royal College of General Practitioners Northern Ireland, Patient and Client Council and the Neonatal Network.
- A preliminary scoping exercise was undertaken in relation to HSC maternity services at a policy, commissioning and service delivery level.
- We undertook a literature review on governance arrangements and safety culture within maternity services to identify key themes and areas of focus.
- We completed a mapping exercise of national standards and recommendations from previous publications relevant to governance and safety within maternity services. A thematic analysis of these standards and recommendations informed the development of an Assurance Framework.
- We utilised our Assurance Framework in order to design and issue structured questionnaires to each HSC Trust.
- We analysed the information returned to us by each HSC Trust and used this to develop Key Lines of Enquiry for meetings with the HSC Trusts.
- Adapting Healthcare Improvement Scotland's 'Maternity Services Patient Safety Survey', we designed and disseminated an online survey on Safety Culture to HSC maternity staff.
- We conducted structured focus groups with a range of advocacy organisations and service user groups to understand the experience of service users across all five HSC Trusts.
- Our Expert Review Team conducted meetings with relevant senior management and frontline staff from staff groups in each HSC Trust. These included meetings held during virtual fieldwork sessions and site visits to each HSC Trust.
- We utilised our Assurance Framework to methodically analyse the information gathered through our meetings, structured questionnaires, focus groups and survey responses in order to determine our key findings and recommendations.

1.4 Assurance Framework

The Assurance Framework for this review was an evidence-based tool, developed by RQIA and agreed by the Expert Review Team. It provides indicators by which governance within maternity services can be assessed. Aligned to RQIA's four domains of Well-Led, Safe, Effective and Compassionate, it is modelled on existing governance frameworks and underpinned by national standards and recommendations from relevant reports.

The frameworks, standards and recommendations used to inform the development of the Assurance Framework are outlined in Appendix A.

Section 2: Maternity Services

2.1 Reducing avoidable harm within maternity services

All maternity services should aim to achieve safe birth outcomes for women and babies. It is recognised world-wide that a failure to deliver safe maternity care has far reaching consequences²⁶. Adverse neonatal outcomes can result in lifelong disability, impacting not only on the child, but also on the woman and her wider family. Equally, the loss of a baby during pregnancy and following birth can lead to profound psychological trauma for the family involved²⁷. Pregnancy-related complications can cause significant morbidity for women and can increase the risk of maternal mortality; the death of a woman in pregnancy or following the birth of a child is a sad and tragic outcome that all maternity services should consistently strive to avoid.

Secondary to the human cost of avoidable harm, there is a substantial financial cost. At 31st March 2022, £109.2 million had been paid in relation to HSC obstetric negligence cases that were open at any stage during the financial year 2021/22^{iv}; accounting for 62% of all monies paid on clinical and social negligence cases within HSC.³ Any improvement work undertaken to enhance safety within maternity services is likely to be both cost saving and produce immeasurable benefits in terms of improving long term outcomes for women, babies and families.

Since the Kirkup Review in 2015, which highlighted serious failings at Morecambe Bay maternity unit, there has been a national commitment to improving safety within NHS maternity services in England. In November 2015, the UK government announced its ambition to reduce the rate of stillbirths, brain injuries, neonatal and maternal deaths in England by 50%²⁸. It has subsequently been determined that this target should be met by 2025²⁹.

The Royal College of Obstetrician and Gynaecologists (RCOG) Each Baby Counts programme commenced in January 2015 and aimed to reduce the number of term babies who die or are left severely disabled as a result of incidents during labour³⁰. The RCOG launched the Saving Babies Lives Care Bundle in 2016 which aimed to reduce perinatal mortality by implementing best practice in relation to smoking cessation in pregnancy, raising awareness of reduced fetal movement, fetal monitoring in labour and risk-based fetal growth surveillance³¹. Saving Babies Lives 2 was introduced by NHS England in 2019 and incorporated an additional element of reducing preterm births. Saving Babies Lives 2 is endorsed by the Maternity Collaborative and Public Health Agency in Northern Ireland. A regional Saving Babies

^{iv} It is important to note that this refers to the cumulative amount paid on open obstetric negligence cases over a number of years, and not just money paid in the 2021/22 financial year.

Lives 2 working group has been established which aims to support implementation across HSC Trusts.

In addition to these interventions, the model of midwifery care has evolved. In 2016 NHS England published a report on 'Better Births, Improving Outcomes of Maternity Services in England' which recommended that all women have a named midwife and are looked after by the same clinical team throughout pregnancy, birth and the postnatal period³². The subsequent Maternity Transformation Programme sought to implement this continuity of midwifery carer model within England and Wales³³. Similarly, the 'best start: five-year plan for maternity and neonatal care', published in 2017, saw the implementation of a continuity of midwifery carer model in Scotland³⁴. In alignment with national programmes, the 2019 NMC Future Midwife standards of proficiency set out UK-wide expectations for midwifery care and promote a continuity of midwifery carer model³⁵. The continuity of carer approach has since been endorsed in Northern Ireland and planning for the implementation of a continuity of midwifery carer model within HSC commenced in 2021.

Recent inquiries into failings within Shrewsbury and Telford NHS Trusts (2020) and East Kent (2022) have renewed a UK-wide focus on safety within maternity services and have reinforced the need to improve governance and safety culture within HSC Trusts, as well as how services are planned, developed and quality assured at a regional level.

2.2 Strategy for Maternity Care in Northern Ireland

The model of maternity provision in Northern Ireland is determined by DoH. DoH aims to improve health outcomes for women and babies through the development of health and workforce policy, and by setting the strategic direction of HSC maternity services. In July 2012, DoH launched its Maternity Strategy for Northern Ireland, 2012-2018. It aimed to provide women and families, HSC staff, commissioners and policy makers with a clear pathway for maternity care from pre conception through to the postnatal period. Adopting a health improvement approach, it set out 22 objectives for achieving six outcomes:

- to give every baby and family the best start in life;
- effective communication and high-quality maternity care;
- healthier women at the start of pregnancy (preconception care);
- effective, locally accessible, antenatal care and a positive experience for prospective parents;
- safe labour and birth (intrapartum) care with improved experiences for mothers and babies;
- appropriate advice, and support for parents and baby after birth.

The legacy HSC Board (now the Strategic Planning and Performance Group) and Public Health Agency were tasked with leading the Maternity Strategy Implementation Group (MSIG), which reports annually to DoH on progress in implementation.

2.3 Nursing and Midwifery Workforce Planning for HSC Maternity Services

In 2016, DoH published 'A Workforce Plan for Nursing and Midwifery in Northern Ireland 2015 – 2025'³⁶. Underpinned by Skills for Health Six Steps Methodology for Integrated Workforce Planning³⁷, it outlined 10 recommendations to ensure that the future nursing and midwifery workforce meets the needs of the population.

In 2016, as an output of the Health and Wellbeing Strategy 2026, the then Northern Ireland Health Minister commissioned a Nursing and Midwifery Task Group with the aim of establishing a 'roadmap' to achieve world class nursing and midwifery services in a reconfigured HSC system over a period of 10 -15 years³⁸.

The Nursing and Midwifery Task Group published its report in March 2020³⁹. Taking into account, the new mandatory Nursing and Midwifery Council (NMC) Future Nurse Future Midwife (FNFM) proficiency standards⁴⁰, which launched for midwives in November 2019, the Task Group made 15 recommendations which aimed to maximise the contribution of nursing and midwifery to deliver person centred care and improve health outcomes.

Since then, the Public Health Agency has completed Phase 11 of its Delivering Care Midwifery Staffing Review in November 2022, which sets out midwifery staffing requirements for all five HSC Trusts⁴¹.

2.4 Service Commissioning

HSC maternity services are commissioned by Strategic Performance and Planning Group (SPPG) at DoH. SPPG works in partnership with the Public Health Agency to commission HSC maternity services through five local commissioning groups, which correspond to each of the five HSC Trusts⁴². For the financial year 2022 – 2023, the budget for HSC maternity services was just over 222 million pounds.

Maternity services are planned and commissioned based on an assessment of the needs of the local population. At the time of fieldwork a Maternity Population Needs Assessment was underway; however, a copy of the draft report was not available to RQIA.

Following decriminalisation of abortion in 2019 and the subsequent introduction of the Abortion Regulations (NI) 2020, work has been underway to commission HSC abortion services⁴³. Early Medical Abortion services are currently provided across all five HSC Trusts. At the time of fieldwork, plans were in place to commence second trimester and surgical abortion services to ensure that all women who require abortion care in

the circumstances set out within the legal framework, can receive this within HSC in Northern Ireland. However, until HSC abortion services are established in full, some women will require to travel to Great Britain.

As was the case prior to legislative reform, all women who require abortion in circumstances that pose a risk to life should receive urgent abortion care provided locally by professionals working within HSC maternity services.

2.5 Service Provision

Hospital and community-based HSC Maternity Services are delivered across all five HSC Trusts in Northern Ireland.



Figure 1: Locations of Hospital based HSC Maternity Services in Northern Ireland

Shared care and consultant-led services are provided by a number of professionals including consultant obstetricians, midwives and GPs. In addition to consultant-led services, each HSC Trust also has a dedicated team of community midwives who

provide antenatal, intrapartum and postnatal care to women who live within the HSC Trust area.^{v,vi,vii,viii}

Intrapartum care is provided in a variety of environments. These include consultant-led obstetric units (known as delivery suites), or midwifery-led units which are located alongside consultant-led units, or in a woman's home. There are currently no freestanding midwifery led units providing intrapartum care in Northern Ireland. All HSC Trusts offer home birth services to support women who opt to have their baby in their home environment. The home birth service in Western HSC Trust was suspended temporarily due to staffing pressures and resumed in November 2022.

Belfast HSC Trust

Royal Jubilee Maternity Hospital

The Royal Jubilee Maternity Hospital (RJMS) is the largest maternity unit in Northern Ireland. It provides maternity care to women from the Greater Belfast area and to women and babies from outside the Greater Belfast area who require specialist maternity or neonatal care. The regional neonatal service is located within RJMS.

Each year, approximately 5000 babies are born in the RJMS. Accommodation within the unit includes 13 rooms within the delivery suite and four midwifery led rooms co-located within the alongside midwifery led unit which is known as the Active Birth Centre (ABC Unit). The freestanding Midwifery Led Unit in the Mater Hospital has been closed to births since the beginning of the COVID-19 pandemic.

Women with obstetric risk factors are advised to give birth on the delivery suite, while women with low risk pregnancies can choose to give birth in the active birth centre (ABC Unit). Pregnant women who present with urgent problems are assessed in the five bedded admissions unit.

Other services provided by the RJMS include the Regional Fetal Medicine Unit^{ix} (FMU), the Day Obstetric Unit, inpatient wards, outpatient clinics and the Maternity Assessment Unit.

There are dedicated consultant-led clinics in RJMS which provide antenatal care to women requiring specialist input for pre-existing medical conditions or for social complexity. Specialist clinics include:

- Endocrinology / Diabetes

^v [Community midwives | Belfast Health & Social Care Trust \(hscni.net\)](https://www.hscni.net/Community-midwives)

^{vi} [Maternity Services - Northern Health and Social Care Trust \(hscni.net\)](https://www.hscni.net/Maternity-Services-Northern-Health-and-Social-Care-Trust)

^{vii} [Maternity | South Eastern HSC Trust \(hscni.net\)](https://www.hscni.net/Maternity-South-Eastern-HSC-Trust)

^{viii} [Maternity Services | Western Health & Social Care Trust \(hscni.net\)](https://www.hscni.net/Maternity-Services-Western-Health-and-Social-Care-Trust)

^{ix} A Fetal Medicine Unit (FMU) offers diagnosis and treatment of complications which may arise in unborn babies.

- Cardiology
- Haematology
- Neurology
- Pre-term Surveillance Birth Clinic
- Obesity clinic
- Birth Choices Clinic
- Multiple Births Clinic
- Clinic for young mothers
- SWAN (Social Wellbeing and Antenatal Complexity) Clinic

Consultant-led antenatal clinics are also held on the Mater Hospital site.

Northern HSC Trust

Maternity units in both Antrim Area and Causeway Hospitals provide maternity care across the Northern HSC Trust area, which is the largest geographical trust in Northern Ireland. The Trust also provides services to Rathlin, the only inhabited island off the coast of Northern Ireland^x. Every year approximately 3700 babies are born in the Northern Trust area; approximately 2800 in Antrim and 900 in Causeway Hospital. Consultant-led and midwifery-led antenatal clinics are held on the Antrim Area and Causeway Hospital sites.

Other services provided by the Northern HSC Trust include an Early Pregnancy Assessment Service and a Fetal Maternal Assessment Unit both based in both Antrim Area Hospital and Causeway Hospital.

Antrim Area Hospital

The delivery suite in Antrim Area Hospital has one birthing pool, and six delivery rooms, one high dependency room and two theatres. It has a six bedded Induction of Labour Bay and 29 inpatient beds for antenatal and postnatal inpatient care.

Causeway Hospital

Causeway Hospital has a delivery suite comprising a birthing room with a pool, three delivery rooms and a dedicated obstetric theatre within the main theatre suite. It has 15 inpatient beds for antenatal and postnatal inpatient care.

South Eastern HSC Trust

Every year approximately 4500 babies are born in the South Eastern HSC Trust area. Prior to the COVID-19 pandemic, approximately 4000 of these births would have been in the Ulster hospital with the remainder in Lagan Valley and Downe Midwifery Led

^x [Home - Northern Health and Social Care Trust \(hscni.net\)](https://www.hscni.net)

Units. At the time of reporting, Lagan Valley and Downe do not provide intrapartum or inpatient maternity care.

Ulster Hospital

In the Ulster Hospital the Maternity Ward consists of four four-bedded bays and 16 side rooms. The delivery suite has seven birthing rooms in total, one of which has a birthing pool. One of these rooms comprises a self-contained bereavement suite for those that have experienced pregnancy loss. There are two theatres with a three bed recovery area as well as a six bed induction of labour bay. The Maternity Unit also has a seven bed 'Home from Home' alongside midwifery led unit with a birthing pool in each room.

Downe Hospital

The Downe Midwifery Led Unit, was a three bedded unit for low risk women, which previously had a birth rate of around 100 births per year. The Downe Hospital has been closed to births and inpatient maternity services since the beginning of the COVID pandemic in 2020.

Lagan Valley Hospital

The Lagan Valley Midwifery Led Unit previously accounted for 50 - 100 births per year. However, a temporary pause on intrapartum care was put in place in March 2022. The decision was made by the South Eastern HSC Trust following two Serious Adverse Incidents (SAIs), in addition to concerns surrounding a reduced number of births in the unit and increased transfer times for emergency transfers. SPPG and PHA completed a review of the quality and safety of the service in June 2022. The temporary pause on intrapartum care remains in place. The decision to re-open is subject to the outcome of a review undertaken by DoH at the request of the coroner following a recent inquest.

Antenatal clinics continue to be provided on the Ulster, Downe and Lagan Valley Hospital sites.

Other services provided by the South Eastern HSC Trust include an Early Pregnancy Clinic (EPC), Emergency Obstetric Clinic (EOU) and a Fetal Assessment Clinic.

There are a number of specialist antenatal clinics provided on the Ulster Hospital site including:

- Haematology clinic
- Twins clinic
- Perinatal Mental Health clinic
- Diabetic and Endocrine clinic
- Fetal Medicine clinic

Southern HSC Trust

Each year approximately 5300 babies are born in the Southern HSC Trust; this is the highest number of births of all HSC Trusts in Northern Ireland. Intrapartum services are provided in Craigavon Area Hospital and Daisy Hill Hospital.

Other services provided by the Southern HSC Trust include an Early Problem Pregnancy Clinic (EPPC) based at Craigavon and Admission and Assessment Units on both hospital sites. There is a Day Obstetric Unit located on the Craigavon Hospital site.

Consultant Led antenatal clinics are located in Craigavon, South Tyrone, Armagh and Daisy Hill Hospital sites.

Craigavon Hospital

In Craigavon hospital, there are approximately 4,000 babies born annually. There are eight birthing rooms, two theatres and a three bedded recovery / high dependency area. There are eight birthing rooms in the alongside Midwifery Led Unit. Craigavon has 30 inpatient maternity beds.

Craigavon maternity unit acts as the secondary referral unit for other hospitals within the Southern HSC Trust area therefore women with high risk pregnancies are looked after in Craigavon instead of Daisy Hill.

Daisy Hill Hospital

In Daisy Hill there is a delivery suite with four birthing rooms, two Midwifery Led birthing rooms and two obstetric theatres. There are also 22 inpatient maternity beds.

Western HSC Trust

Each year, approximately 3,700 babies are born in the Western HSC Trust. The Western HSC Trust has two maternity departments, based at Altnagelvin Hospital in Derry / Londonderry and the South West Acute Hospital in Enniskillen.

Other services provided by the Western HSC Trust include maternal and fetal assessment services provided in Altnagelvin Hospital, South West Acute Hospital and in the Omagh Hospital and Primary Care Centre. There are Early Pregnancy Assessment Services in both Altnagelvin and SWAH.

Consultant-led antenatal clinics are provided in Altnagelvin, SWAH, Omagh, Strabane and Limavady. Midwifery led antenatal clinics are provided in Altnagelvin, Shantallow, Strabane, Limavady, SWAH, Omagh and Linaskea.

Altnagelvin Hospital

In Altnagelvin Hospital, there is a delivery suite with five delivery rooms, one theatre and one recovery room and an alongside midwifery led unit with seven rooms which includes two birthing pools. Due to staffing pressures the alongside MLU service is not always available.

South West Acute Hospital

In South West Acute Hospital (SWAH), there is a delivery suite with five delivery rooms, a two bedded observation area and an alongside midwifery led unit with six rooms with two birthing pools. There are 10 inpatient maternity beds.

Omagh Hospital and Primary Care Centre

At Omagh Hospital there is a maternal and fetal assessment unit for women who require assessment by a midwife. There are no births at Omagh Hospital.

Neonatal services

Seven neonatal units deliver care across the five HSC Trusts in Northern Ireland. There are three levels of neonatal care:

- Level 3 - Special Care
- Level 2 - High Dependency Care
- Level 1 - Neonatal Intensive Care

The Royal Maternity Hospital, within the Belfast HSC Trust, is the regional Neonatal Intensive Care Unit (NICU) providing Levels 1 – 3 care to infants of all gestations. It provides the regional service for extremely preterm infants and those who have complex medical or surgical needs.

In addition to the NICU, there are four Local Neonatal Units (LNUs), providing Level 1 – 3 care, in Antrim Area Hospital, the Ulster Hospital, Craigavon Area Hospital and Altnagelvin Hospital.

Level 3 care is provided in Special Care Baby Units (SCBUs) at Daisy Hill and the SWAH.

All neonatal units operate as part of the Neonatal Network Northern Ireland which was established in 2013.

The Neonatal Network Board comprises membership from all HSC Trusts, SPPG, PHA and TinyLife^{xi} The network aims to facilitate the planning, coordination and

^{xi} Tiny Life is a premature and vulnerable baby charity based in Northern Ireland.

development of services with a focus on standardising care pathways and driving improvements in neonatal outcomes.

2.6 Monitoring quality and safety within HSC maternity services

Each HSC Trust is accountable for the quality of the services it delivers and has a duty to ensure effective systems for the monitoring and oversight of quality and safety. At a regional level, there are a variety of mechanisms through which the performance of HSC maternity services is monitored:

Strategic Performance and Planning Group (SPPG)

SPPG (formerly HSCB) is responsible for monitoring the quality and safety of the services it commissions. Each HSC Trust provides SPPG with assurance information on a quarterly basis. Since the closure of HSCB in March 2022, and the establishment of SPPG as a branch of the DoH, work is underway to modernise the model of commissioning and performance monitoring in Northern Ireland.

Regional Maternity Dashboard

The Maternity Dashboard is managed by Performance Management and Service Improvement (PMSI) at Strategic Planning and Performance Group (SPPG) and can be accessed by management and clinical staff within HSC Trusts. The Maternity Dashboard extracts data from NIMATS, the regional information system for HSC maternity services. This allows for regional comparison across a range of clinical indicators. At the time of fieldwork, dashboard indicators were being updated to align with 'Saving Babies Lives 2'.

Northern Ireland Maternal and Child Health Office (NIMACH)

The Northern Ireland Maternal and Child Health Office (NIMACH) is based within the Public Health Agency. NIMACH collects and analyses mortality outcomes in relation to stillbirths, neonatal and maternal deaths. NIMACH contribute to national audits via MBRRACE-UK, which is responsible for conducting the National Confidential Enquiry into Maternal Deaths (CEMD)⁴⁴ and national surveillance of late fetal losses, stillbirths and infant deaths⁴⁵.

Neonatal Intensive Care Outcomes Research and Evaluation (NICORE)

Neonatal Intensive Care Outcomes Research and Evaluation (NICORE) collate outcomes data from Northern Ireland neonatal units which can be used for national benchmarking. NICORE is funded by DoH and is jointly overseen by PHA and Queens University Belfast (QUB).

Quality Experience Group

SPPG / PHA have a role in overseeing SAIs and complaints within HSC in Northern Ireland. The Quality Safety Experience group meets monthly and has a primary focus

on learning. It initiates Thematic Reviews identified from trend and theme analysis of incidents.

Regional learning identified through thematic review of maternity SAIs is disseminated via three key mechanisms:

- Safety Quality Reminder Letters and reminder of best practice letters;
- Learning Matters newsletter;
- Maternity Collaborative.

Section 3: Review Findings

3.1 The views and experiences of service users

First and foremost in this review are the views and experiences of service users. Understanding the experiences of those who use maternity services is a vital aspect of evaluating how services, and the healthcare system as a whole, support women during pregnancy, birth and the postnatal period.

As part of this review, RQIA conducted semi-structured focus groups with a range of service user groups, advocacy groups and voluntary agencies; all of which provided an insight into the experiences of maternity service users across the five HSC Trusts. During focus group sessions, the Expert Review Team (ERT) explored themes such as person centred care, dignity and respect, involvement of birth partners, informed choice, mental health support, bereavement support, and HSC Trust response to complaints and incidents.

The service user representatives and advocacy groups with whom we met reported that, on the whole, women and their families experienced satisfactory maternity care. They acknowledged the commitment of midwives and doctors to providing an effective service and some were exceptionally complimentary of the kindness and compassion women experienced from individual practitioners. However, it was also reported that services and staff were recognised to be under pressure and that this in turn can impact on patient experience. It was highlighted to RQIA that the systems within which maternity staff work do not always enable them to provide the tailored care and support that women and their families wish to receive.

For those who experienced it, women reported an appreciation for continuity of care, when they saw the same midwife or obstetrician at each appointment and had established a rapport with them. One woman who had received consultant-led care for a high-risk pregnancy told us:

“I had an amazing journey with my second baby; I saw the same doctor at each appointment and was given a number to ring if I needed anything”

It was stated that a lack of continuity of care impacted on patient experience; some women reported frustration and upset at healthcare professionals not reading their medical notes and therefore not knowing details of their history prior to meeting them. This was said to be particularly upsetting in circumstances where there had been a previous pregnancy loss or bereavement.

It was also reported that antenatal appointments can be experienced as rushed, reflecting the pressure services are under, resulting in some women feeling that they

have not had sufficient opportunity to ask questions or to relay their concerns and anxieties. We heard that the regional maternity handheld record contains a page which facilitates the woman to record questions and that this was beneficial, enabling clinicians to see what matters to the patient during the consultation.

Despite a shift towards person-centred care since the publication of the last Maternity Strategy in 2012, some women felt that obstetricians and midwives adhered too rigidly to risk-based care pathways and that this impacted on the level of information provided on other options available to them. We heard examples of how women with pre-existing, yet well-controlled, medical conditions felt that their birthing options were unnecessarily restricted without satisfactory explanation from their healthcare provider. Women expressed a clear preference to receive information on a full range of antenatal and birth choices, to be given autonomy and treated as partners in the decision-making process. We heard that, in lieu of experiencing this approach from healthcare providers, women often sought information from peer support networks and advocacy groups.

There was a consistent view that midwifery led units should be better promoted and more accessible. Some women reported that the criteria for admission were too restrictive, and as a result of being denied the option of birthing in an MLU more women were choosing to birth at home. Whilst home births also have suitability criteria, community midwifery teams will also support those who seek 'care outside guidance' since the alternative is that women 'free birth' without any midwifery assistance.

We heard from women who had been supported to birth in midwifery led units and reported very positive experiences in relation to the dignity and respect shown to them by midwives; similarly, those who had chosen to birth at home valued the respect and autonomy that was afforded to them by attending healthcare professionals.

Experiences were more variable for those who had given birth within an obstetric unit. We heard from some women who felt that value judgements were regularly made by maternity staff on the type of birth, with vaginal birth commonly being referred to as 'normal', implying that caesarean birth was not normal and therefore less acceptable. It was reported by a number of women that whilst their midwife treated them with dignity and respect in labour and during birth, they did not always experience this same level of respect from the wider team.

Similarly, the experience of birth partners was said to vary depending on individual practitioners and care setting. The women we spoke with were keen to highlight the important role played by birth partners and expressed a desire for greater involvement across all aspects of their care. The COVID-19 pandemic was stated to have had a detrimental impact on the involvement of birth partners in supporting women through pregnancy, birth and in the postnatal period. Some women and advocacy groups were exceptionally critical of ongoing restrictions to partners visiting postnatal wards.

We heard from a number of groups that postnatal care and support could be strengthened across a number of areas. Women expressed a preference for more support in caring for their new born whilst in hospital and, in particular, with breast feeding. Women reported that the availability of perinatal mental health and psychology services varied across HSC Trusts and that physiotherapy input was not always provided in a timely manner.

A number of women whose babies had been admitted to the neonatal unit reported experiencing a lack of understanding and sensitivity from staff during their stay on the postnatal ward. It was stated that more could be done to support women in these circumstances by way of psychological support, breast feeding support and by facilitating women to see their babies as soon as possible after birth; separation from babies was stated to be deeply distressing for women, particularly for those who had experienced traumatic births.

It was stated by a number of women that an extended period of postnatal support, beyond the statutory 10 days, would be welcomed and that the important care provided by community midwives and health visitors in the postnatal period was much appreciated. The advocacy groups we met with highlighted the need for enhanced support in the postnatal period for women with social complexity. In particular, it was felt that a co-ordinated multiagency approach would be beneficial to improve outcomes for vulnerable women and babies.

The ERT heard that the absence of a first trimester screening programme has limited women's choice and created a disparity with the rest of the UK. It was reported that women are not made aware of the possibility of trisomy screening since it is not routinely available within HSC. We heard how women, diagnosed with a fatal fetal abnormality, who choose to carry the pregnancy to term, can feel that their birth choices are limited as they are encouraged to have a vaginal birth rather than a caesarean birth.

For women who sadly experienced a stillbirth or neonatal death, we heard of significant delays in receiving post-mortem results, which added to the distress of some grieving parents who wished to conceive again. We heard that in some cases the arrangements for providing post-mortem results felt impersonal; one woman reported receiving her baby's post-mortem results over the phone.

The bereavement support provided by bereavement midwives was described as invaluable. Women praised the dedication and kindness of individual bereavement midwives who had supported them through very difficult times. One woman told us:

“My bereavement midwife was an angel. I felt like I could tell her anything and not be judged. She let me know it was okay to have difficult and challenging feelings.”

Women also spoke positively of the miscarriage support provided to them by staff working within Early Pregnancy Clinics. However, it was reported that Emergency Department (ED) staff did not always demonstrate the same level of compassion or understanding towards women with a history of pregnancy loss, which likely reflects a lack of experience, training and significant competing priorities within busy EDs.

The ERT explored the support available for women following adverse incidents. They heard that women do not always wish to pursue a formal complaint or adverse incident investigation and instead would prefer that staff are facilitated to sit down with them soon after the incident, to provide an explanation of events and an opportunity to ask questions. It is within this setting that women would like to hear an apology. It was the view of advocacy groups that HSC Trusts should do more to support staff to say sorry and provide an explanation at an early stage; this would lessen the distress experienced by women, and may avert the need for a formal complaints process or pursuance of a medico-legal route.

The ERT heard that when women do choose to pursue a complaints process, the correspondence from HSC Trusts can feel generic and impersonal and there is a sense that HSC Trusts do not seek to derive learning from complaints in order to improve services. Similarly, we heard that women and families experience the Serious Adverse Incident (SAI) process as protracted, bureaucratic and lacking in compassion, leading them to approach advocacy organisations such as Patient Client Council for information and support.

Women reported that groups such as Patient Client Council, Maternity Service Liaison Committees, maternity support groups, charities and other advocacy groups were vital in supporting them to navigate the healthcare system, understand the options available to them and support them through their experience of pregnancy, birth and, in some sad cases, loss.

Advocacy groups highlighted to us that not all women experience services to be accessible or person centred, and that women from vulnerable groups can find it difficult to attend appointments and are more likely to experience discrimination within maternity settings. These groups included young women, women from rural communities, women from the travelling community, transgender people, asylum seekers, refugees and women from the Roma community.

Women from ethnic minority backgrounds, who do not have English as a first language, were said to be particularly disadvantaged in trying to navigate an unfamiliar HSC system. We heard of the significant challenges faced by ethnically diverse women in becoming registered with GPs and dentists during pregnancy. The online self-referral system for accessing antenatal booking appointments was said to be additionally challenging for women from cultural and socio-economic backgrounds

where there may be limited experience in using technology. It was reported that some women have low levels of literacy in their own language and, although accompanied to appointments by an interpreter, may find it difficult to understand medical or technical language when it is translated. Advocacy groups highlighted to us that as interpreters must provide a direct translation of what is said by clinicians, additional steps such as the use of plain language, checking the woman's understanding, and providing written documentation to summarise the consultation would greatly assist women to understand the clinical findings and proposed treatment plan.

The ERT considers that maternity services should be accessible to all who need them and barriers which impact on patient experience and safety should be examined and addressed.

Care Opinion Maternity Stories

Care Opinion is an independent feedback platform, where service users can share stories of their experience of HSC services. Care Opinion conducted an analysis of all stories submitted by maternity service users between 3 August 2020 – 3 August 2022. The full report can be found [here](#).

550 stories were submitted during this timeframe. A thematic analysis identified six themes that were important to women in their experience of maternity care:

- The importance of compassion
- Empowerment and the importance of listening
- Recognition of the role of the birth partner during labour
- High standard of care
- Empathetic response to difficult or emergency situations
- Importance of access to mental health services or peer support

In analysing the stories, Care Opinion also assigned a 'criticality rating' and determined that 76% were 'not critical'; i.e. these represented wholly positive feedback. A thematic analysis identified a number of themes that reflected good care:

- Staff including midwives and doctors
- Reassurance and support
- Compassionate, empowering and person-centred care

24% of stories were found to be mildly to moderately critical. In terms of what could be improved, the following themes were identified:

- Communication
- Staff attitude
- Room temperature
- Visiting restrictions due to COVID-19 pandemic

Only 6% of stories were scored as highly critical of the care provided. The main themes of these stories comprised:

- Difficulty accessing help
- Difficult labour / birth
- Concerns not acted upon
- Visiting restrictions due to COVID-19 pandemic

3.2 Regional approach to assuring and improving safety within HSC Maternity Services

3.2.1 Vision and strategic direction

A key feature of safety within NHS maternity services is ‘a commitment to safety and improvement at all levels, with everyone involved’⁴⁶. This is best exemplified by the presence of a clear vision and strategic direction. The process of developing a vision for safety within maternity, co-produced by all relevant stakeholders, including service users, clinicians, managers and the Trust Board, can serve to ensure an intentional approach to safety that is understood by all.

The ERT found that HSC Trusts were at differing stages of their journey in relation to vision development. Just one HSC Trust had completed the development of a vision which was understood by staff at all levels. The process of development had ensured a strong safety ethos which was evident across all staff groups from ground level up to the HSC Trust Board.

Good Practice Example: Northern HSC Trust Vision for Safety within Maternity

The Northern Health and Social Care Trust (NHSCT) vision for Maternity services is: *“Women and their families will experience a highly positive journey throughout pregnancy, birth and postnatally, safely cared for by kind, respectful and professional staff.”* This vision was developed through a vision mapping exercise at a senior midwifery workshop in 2019 and endorsed by wider multidisciplinary teams.

NHSCT vision for Improving Safety within maternity services is: *“To continuously improve safety for women, babies and families.”*

NHSCT plan to achieve this by:

- Creating the conditions for a culture of safety and continuous improvement
- Working with users of the service to improve the experience of women, families and staff
- Improving our use of data to provide assurances at all levels
- Developing safe and highly reliable systems, processes and pathways of care
- Learning from excellence and error or incidents

Sharing and embedding the vision has been supported by a co-ordinated approach to leadership across the NHSCT and within its maternity services. To underpin this, NHSCT has a piloted a bespoke branded leadership programme **‘Being a #TeamNorth Leader’** under the broader initiative of ‘Team North’.

There was wide variation in the vision and strategy for safety within maternity services across the remaining HSC Trusts. A contributory factor, highlighted by all HSC Trusts, was the lack of an up to date DoH strategy for maternity services. HSC Trusts were of the view that due to the increasing complexity of the maternity population, workforce challenges and the impact on service sustainability, a new DoH-led strategy is required. HSC Trusts considered that a strategy would outline the strategic direction of maternity services, providing commissioners and HSC Trusts with a blueprint for high-quality maternity care in Northern Ireland.

In particular, the absence of regional endorsement of the Ockenden recommendations was cited as a barrier to driving necessary improvements. Whilst work is ongoing across HSC Trusts to implement the Ockenden recommendations, this has been clinician-led, supported by the regional Maternity Collaborative, and has not been underpinned by policy direction or accompanied by additional funding. The ERT was encouraged that, despite these barriers, a proactive approach had been adopted in three HSC Trusts, where managers and clinicians had presented relevant learning and improvement work arising from the Ockenden Inquiry to their respective HSC Trust Board.

Nonetheless, the ERT considered that action undertaken solely at HSC Trust level is unlikely to be sufficient to fully deliver on required safety improvements. Given the significant pressures within HSC maternity services, a regional strategic direction is urgently required in order to ensure a sustained and co-ordinated approach to the delivery, monitoring and oversight of quality and safety within maternity services. The development of a strategy should take into account: learning from national inquiries into NHS maternity services, the complexity of the Northern Ireland maternity population, and the changed landscape within HSC services since the COVID-19 pandemic.

<i>Recommendation 1</i>	<i>Priority 2</i>
1.1 Each HSC Trust should develop a vision for safety within maternity HSC services that is supported by a strategic plan and is clearly understood by all relevant stakeholders. This should be co-produced with involvement from the Trust Board, senior management team, service users and their families, and all maternity staff groups.	
1.2 DoH / SPPG should work with all HSC Trusts, PHA, RQIA, Royal Colleges (RCOG, RCM, RCGP) and service user representatives to develop a new maternity strategy for Northern Ireland which includes a clear focus on safety.	

3.2.2 Quality Assurance

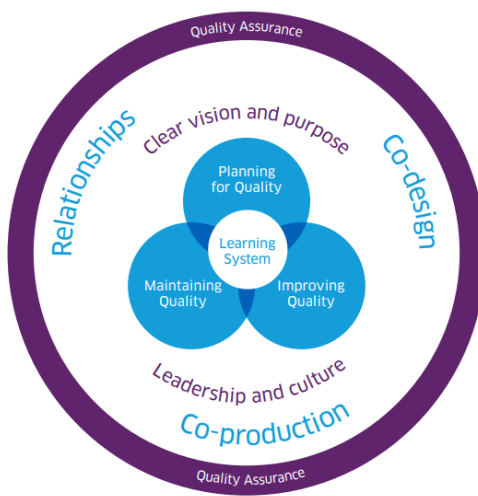
Assuring and improving safety within HSC maternity services is reliant on robust systems for governance and accountability both at Trust Board and commissioning level. Whilst HSC Trusts are accountable for the quality of care delivered and have a statutory duty to have in place governance systems for monitoring and assurance, commissioners have a duty to monitor the quality of services they commission.

Effective systems for monitoring safety within maternity require the use of relevant good-quality data to provide assurance against national standards, allow early identification of concerns and to drive continuous improvement in patient outcomes. Importantly, the safety metrics underpinning such systems must be outcomes focused, risk adjusted where possible, and available in timely manner. They should easily input into systems for trend and theme analysis and be aligned regionally to enable robust monitoring and oversight of commissioned services. Furthermore, nationally-agreed safety metrics should be utilised to provide effective benchmarking with NHS peers.

Within HSC Trusts, Quality Management Systems (QMS) can enable effective quality planning, quality control and improvement at a local level. A functioning QMS not only ensures a consistent approach to planning and improvement, it encompasses the broader elements of assurance, in addition to the monitoring of a wide range of performance indicators. For example, a Quality Management approach to assurance will test the effectiveness of systems for planning and control alongside an assessment of organisational leadership and culture through gathering qualitative feedback from staff and service users⁴⁷.



High-level Quality Management System Framework
(working draft 4)



© Healthcare Improvement Scotland. Published: July 2022
Please note: The QMS Framework is continuously evolving, for the most up to date version please visit: <https://ihub.scot>

The ERT found that no HSC Trust had embedded an effective Quality Management System (QMS) to support quality assurance within maternity services. Given its relatively recent adoption within HSC, combined with the ‘firefighting’ mode HSC Trusts have been forced to adopt since the pandemic, this was not a surprising finding; nonetheless, proper time and investment in building Quality Management Systems is worth considering since it would serve to strengthen assurance and improve consistency in the delivery of safe, effective care.

Furthermore, the ERT found that there was variation across HSC Trusts in the types of metrics used to measure quality and safety within maternity. Underlying this was the lack of regionally agreed metrics housed in a central repository of meaningful performance indicators. The disparate mechanisms whereby data is sought and provided to HSC Trust Boards, SPPG / PMSI, PHA / NIMACH do not provide the overarching view that is needed to identify and address safety concerns at an early stage. It is the view of the ERT that further work is required at a local and regional level to improve the use and availability of data for both assurance and improvement.

It should be acknowledged that these challenges are not unique to Northern Ireland. Nationally work is underway to strengthen the approach to surveillance of quality and safety within NHS maternity services through the use of better data sets, improved systems for oversight and better partnership working across government, commissioners, regulators and providers⁴⁸. The ERT considers that a similar approach would be of benefit within HSC.

<i>Recommendation 2</i>	<i>Priority 3</i>
<p>2.1 Each HSC Trust should develop a Quality Management System that utilises relevant data on both activity and outcomes to facilitate oversight, assurance and improvement of safety within maternity services.</p>	
<p>2.2 DoH / SPPG, PHA, HSC Trusts should work in collaboration with RQIA, GMC / NMC and the Maternity Collaborative to develop regionally agreed metrics for monitoring quality and safety within HSC maternity services. These should be made available through the development of a central repository of data that is accessible to all relevant stakeholders.</p>	

3.2.3 Quality Improvement

A systematic approach to improvement within HSC maternity services requires strong leadership, QI capacity and capability, and QI programmes that are aligned to safety priorities. Investment in QI at the front line has been shown to have benefits not just in improving outcomes for women and babies but in improving staff engagement and staff morale.

Although clinicians across HSC Trusts were able to describe HSC Trust support for QI and the local QI training programmes available, just one HSC Trust had a QI programme of work overseen by a dedicated QI lead or QI team within maternity. Importantly, only some HSC Trusts evidenced a robust process of aligning QI work to safety priorities identified through its maternity governance systems.

Nonetheless, all HSC Trusts recognised the benefits of QI in improving safety within maternity services and were particularly supportive of the work undertaken by Maternity Collaborative.

Good Practice Example The HSCQI Maternity Collaborativeⁱ

The HSCQI Maternity Collaborative is a sub-group of the Maternity Strategy Implementation Group (MSIG) and has cross-trust and multi-professional input.

The Collaborative aims to improve the safety and outcomes of maternal and neonatal care by reducing regional variation in practice to provide a high quality healthcare experience for all women, babies and families across maternity services.

The Maternity Collaborative has led on a number of initiatives:

- Development of a regional guideline on syntocinon administration;
- Introduction of a physiological approach for interpretation of cardiotocographs (CTG) for intrapartum fetal monitoring;
- Development of a Regional Intrapartum Fetal Monitoring Guideline and intrapartum physiological based evaluation tool and checklist, alongside the provision of regional masterclass training for maternity staff;
- Implementation of Saving Babies Lives 2 within HSC Trusts in NI;
- Implementing improvements based on the learning from the Ockenden Inquiry.

Unlike the Neonatal Network Northern Ireland, the Maternity Collaborative does not operate as a fully funded network. Transition to network status requires endorsement from the DoH.

Across all HSC Trusts, clinicians appreciated the cross-Trust, multi-professional ethos of the Collaborative and praised the work that had been undertaken to reduce variation and standardise practice across the region. They considered that with proper investment the Maternity Collaborative could be even more impactful, particularly in relation to implementing the learning from the Ockenden Inquiry, some elements of

which have constraints in terms of time and resource. There was a wide consensus amongst staff members who spoke with the ERT that HSC maternity services would benefit from a formal Maternity Network which had DoH endorsement and recurrent funding.

The ERT considers that the funding and establishment of a Maternity Network, should be underpinned by strong governance arrangements and clear mechanisms for accountability. It would be beneficial if the Maternity Network worked in close partnership with the Neonatal Network and reported directly to the offices of CMO and CNO. Furthermore, the work of the Network should be supported on the ground by dedicated QI teams embedded within HSC maternity services. These teams should comprise frontline obstetricians, midwives and neonatologists with an interest in QI who can oversee the implementation of regional work alongside Trust-specific maternity QI programmes aligned to key safety priorities.

Recommendation 3	Priority 2
<p>3.1 DoH should endorse and fund the Maternity Collaborative as a Maternity Network with a recognised role in improving safety within maternity services across the region. The Maternity Network should be underpinned by strong governance arrangements and clear lines of accountability.</p>	
<p>3.2 The Maternity Network should be supported by DoH / SPPG / PHA to lead a QI programme of work that is aligned to clearly defined regional priorities for improving safety within maternity. Where beneficial, the Maternity Network and Neonatal Network should work together to improve neonatal outcomes.</p>	
<p>3.3 Each HSC Trust should establish multidisciplinary QI teams for maternity to support the work of the Maternity Network and to lead a Trust-specific QI programme of work within maternity.</p>	

3.3 Leadership and safe staffing

3.3.1 HSC Trust Boards and safety within HSC maternity services

Effective leadership structures and reporting arrangements are essential to ensure an appropriate degree of oversight and assurance of quality and safety within maternity services at both senior management and HSC Trust Board level. The flow of information from ground-level up to the Board and from the Board back down requires functional reporting and information-sharing mechanisms, clear lines of accountability and a strong safety culture.

There was variation across HSC Trusts in relation to leadership structures and reporting mechanisms. The ERT found that in all HSC Trusts, the link from maternity services to the HSC Trust Board required strengthening. In most HSC Trusts, the

Head of Midwifery reports operationally to the Assistant Director and professionally to the Director of Nursing, whereas the Clinical Director for maternity services reports either to the Assistant Director or to a Divisional Director / Chair. The resultant effect is that neither the midwifery nor obstetric leadership has direct access to the Trust Board on an ongoing basis, which lessens the opportunity to advocate for improvement within maternity services. It is likely that these arrangements also represent a missed opportunity to maximise partnership working at a senior level and to ensure that equal weighting is applied to information shared through midwifery and obstetric reporting channels.

In addition to effective reporting mechanisms, the degree of interest demonstrated by HSC Trust Boards in relation to maternity services is important in ensuring effective governance arrangements and improving patient outcomes. As Boards have a broad remit and the pressures on acute and unscheduled care often take precedence over maternity, it can be beneficial if HSC Trust Boards have a designated member acting as a safety champion for maternity services. Improving oversight and communication with the Board is all the more important when one considers the human and financial costs of avoidable harm within maternity services.

Following the Morecambe Bay Investigation in 2015, the Safer Maternity Care 2016 action plan recommended that NHS Trusts in England appoint a board-level maternity safety champion to improve oversight and “floor to board” communication⁴⁹. The value of a board-level champion becomes even more apparent when considering the learning from the Ockenden and East Kent inquiries, which found that hierarchical Trust cultures, disinterest at Board level and defensive positions adopted in response to internal challenge and external scrutiny, were not just barriers, but red flags, in relation to safety within maternity services.

At the time of fieldwork, no HSC Trust reported having a board-level safety champion for HSC maternity services. HSC Trusts displayed varying degrees of insight into why it might be helpful, ranging from one HSC Trust which stated that a maternity safety champion was not required to another that had already submitted a proposal for a Board member to act as a champion; the ERT was complimentary of the latter’s proactive approach. By contrast, in one HSC Trust, a non-executive board member did not attend the fieldwork session, despite the request of RQIA. Whilst recognising that conflicting priorities can impact on the availability of Board members, the ERT was concerned that non-attendance could be interpreted as a lack of interest of the HSC Trust Board in the maternity safety agenda, especially since this particular HSC Trust’s maternity services had recently been subject to external scrutiny.

In any case, these findings served to reinforce the view of the ERT that it would be beneficial for HSC Trust Boards to have a non-executive member acting as a safety champion for maternity services. Such a champion should act as a conduit between the head of midwifery, clinical director, front-line staff, service users and the HSC Trust

Board in order to improve ‘floor to Board’ communication and assist the HSC Trust Board in the oversight and assurance of quality and safety within HSC maternity services⁵⁰.

The visibility of senior leaders within any healthcare organisation plays a crucial role in instilling confidence in clinical teams by demonstrating dedication to improving quality and safety, and reducing perceived barriers to raising concerns when issues arise. HSC Trust Boards can play an important role in driving a culture of learning and improvement, empowering staff at all levels to do their job well. The mechanisms for visibility and accessibility of HSC Trust Boards can vary across organisations, but the effectiveness of any approach should be assessed rather than assumed.

Most HSC Trusts reported walk-arounds by Board members and executive teams; yet, this was less frequently recalled by the clinical teams we met with. The ERT considers that Trust Boards should do more to visit maternity units to meet with staff and patients in order to better understand the challenges and also the successes in driving improvements in quality and safety; examples of which can be found across the region.

Recommendation 4	Priority 1
4.1 Each HSC Trust Board should nominate a non-executive member to act as a safety champion for maternity services.	
4.2 The Head of Midwifery and Clinical Director for Maternity in each HSC Trust should be facilitated to liaise directly with the Trust Board on a regular basis; these arrangements should ensure that midwifery and obstetrics are given an equal voice.	
4.3 Each HSC Trust should have effective mechanisms in place to ensure HSC Trust Boards and senior leaders are visible and accessible to clinical teams.	

3.3.2 Strategy for developing maternity healthcare leaders

Safe maternity services require strong leadership at a senior level. Such roles can be demanding and challenging, as well as rewarding. Leadership training needs to be provided in order to foster effective leadership and embed the HSC Collective Leadership Strategy within HSC maternity services⁵¹; promoting shared, collaborative and compassionate leadership at all levels. Building leadership capacity and capability requires both strategy and investment to develop the skills of leaders, and to nurture talent.

The ERT found that most HSC Trusts had a Trust leadership strategy in place which extended to developing leadership capacity and capability within maternity services. Whilst all HSC Trusts were supportive of providing training to staff in leadership roles,

time was reported to be a significant barrier to staff attending courses or enrolling in programmes. The ERT found that midwifery leaders were more often encouraged and supported to avail of leadership training than medical staff; we heard from a Clinical Director in one HSC Trust, who, despite requests, had not received any training or support for the role, which was performed alongside a number of busy clinical commitments. Furthermore, only one HSC Trust had adopted a proactive approach to training both midwives and doctors, reporting that since 2021 a focused effort has been made to ensure midwives and doctors in leadership roles have been offered training through the HSC Leadership Centre to develop knowledge and skills in leading and managing their team.

The paucity of a strategic approach to developing medical leadership capability within maternity services represents an important deficit; especially when one considers a relevant finding of the recent Independent Neurology Inquiry⁵² which stated that *“the fact that a consultant may be outstanding as a clinician does not necessarily translate to being competent as a manager. The roles are distinct and require very different skill sets. This has not been adequately understood....by the medical profession”*; this is a factor previously recognised by the Donaldson report (2014) which recommended that a “clinical leadership academy” be set up in Northern Ireland⁵³.

The ERT considers that leadership competences should not be assumed by virtue of successful appointment to leadership roles. Prior to commencement of post, an assessment of the training required to upskill successful candidates should be undertaken and this training should be provided as early as possible within their induction period; any remaining deficits in skills and competencies should be addressed through a Personal Development Plan. The ERT recommends that there should be regional agreement on the minimum skills, competencies and training requirements for healthcare staff undertaking leadership roles and a regional training programme to upskill leaders in medical management roles would be beneficial.

Recommendation 5

Priority 2

- 5.1 DoH / SPPG and HSC Trusts should work together to define the minimum skills, competencies and training requirements for specific HSC Trust management roles in relation to maternity services.
- 5.2 DoH / SPPG and HSC Trusts should consider working with the HSC Leadership Centre to design and implement a regional training programme for medical leaders working within HSC at Clinical Director level and above.

3.3.3 Safe staffing of HSC Maternity Services

Safe staffing is a prerequisite for safe maternity care. Achieving positive outcomes within maternity services is reliant on women and babies receiving the right care, in the right place, at the right time from the right professional. Service capacity and capability relies on the full gamut of workforce planning, recruitment, staff training, development and retention to ensure that there are sufficient numbers of staff with the right skill mix to deliver safe effective care; at all times.

Effective workforce planning requires the use of evidence-based tools and methodologies to determine staffing numbers and skill mix based on current and predicted population need. It is a complex process that takes considerable time and effort; however, its proper execution is necessary to ensure the delivery of safe sustainable services.

Staffing maternity units based on the number of births has long been demonstrated to be inadequate⁵⁴. Modern workforce planning should incorporate factors such as case-mix, complexity and acuity. Furthermore, staffing models should take account of predictable absence such as annual leave, maternity leave, study leave requirements and typical sick leave absence to ensure there is resilience within services to respond in times of acute pressure.

Birthrate Plus is a commonly used methodology for planning midwifery staffing levels and skill mix within UK maternity units. It is a well-tested, validated tool that assesses case-mix, medical complexity and acuity to produce outputs consistent with NICE safe staffing standards⁵⁵ for midwifery staffing. At the time of fieldwork, the Public Health Agency Delivering Care Initiative had completed Phase 11 of its Delivering Care Midwifery staffing review. Birthrate Plus methodology had been applied to all five HSC Trusts to determine the number of Whole Time Equivalent (WTE) clinical establishment required for each unit. This review concluded that there was a shortage of 47.54 WTE midwifery clinical staff and 33.35 WTE non-clinical / management staff for the region, equating to a total deficit of 80.93. It is important to note that the Birthrate Plus calculation of non-clinical and management requirements relates to specialist midwifery and senior midwifery management roles and does not include an assessment of the need for non-midwifery management roles, administrative staff or ancillary staff. The ERT considers that a holistic approach to workforce planning should take account of the broad spectrum of roles required for the effective and safe functioning of maternity services.

During fieldwork, the ERT heard from management and clinicians across HSC Trusts who were of the view that the outputs from the Birthrate Plus exercise were not in keeping with the funded establishment required to meet the needs of the maternity population. One shortcoming of the Birthrate Plus methodology is that it does not take account of social complexity, a factor which has increased considerably in recent

years. The ERT considered that Birthrate Plus remains a valid methodology but should not be used in isolation as a standalone tool. Where the professional judgement of commissioners and providers indicates that additional staffing is warranted to meet the needs of a socially vulnerable population, Birthrate Plus should be augmented by a further assessment to determine the required additionality. The use of a Professional Judgement Tool^{xii} to estimate workload requirements can be helpful in this regard⁵⁶.

Recommendation 6

Priority 2

- 6.1 SPPG, PHA and HSC Trusts should augment the Birthrate Plus analysis with an assessment of the additionality required to meet the needs of the population with social complexity. In lieu of formal methodology to determine such additional staffing requirements, commissioners and providers should exercise their professional judgement; the use of a Professional Judgement Tool should be considered.
- 6.2 SPPG, PHA and HSC Trusts should ensure that workforce planning for maternity services takes account of the need for managerial, administrative and ancillary staff, in addition to clinical staff.

3.3.4 Medical staffing

Unlike workforce planning for midwifery, there is no Birthrate Plus equivalent for planning the numbers of maternity medical staff. The RCOG is in the process of developing a 'Safe Staffing in Maternity Tool', as part of a workforce planning exercise commissioned by Department of Health and Social Care (DHSC), to quantify the number of obstetricians and obstetric anaesthetists required to safely staff maternity units in England, Scotland and Wales. This is due to complete in Spring 2023 and does not presently extend to Northern Ireland⁵⁷.

The ERT heard concerns across three HSC Trusts regarding a shortage of anaesthetists, impacting on the availability of dedicated out of hours' anaesthetic cover for maternity. This poses challenges for the safe delivery of care and can lead to delays in the provision of epidural pain relief as the onsite anaesthetist also covers Intensive Care / High Dependency Units and emergency theatres. Both RCOG and Royal College of Anaesthetists (RCOA) standards state that anaesthetists covering maternity services should be able to respond immediately to emergency work on the delivery suite and should not be primarily responsible for elective obstetric work or other duties such as ICU^{58,59}; furthermore, the standard for epidural care is that women should not wait longer than 30 minutes for an anaesthetist to attend⁶⁰. The ERT heard in one HSC Trust, that the issue surrounding anaesthetic cover had been on the directorate risk register for over a decade and it was not clear to anaesthetic teams

whether it had been escalated to commissioners. The ERT considers that this deficit must be addressed and that anaesthetic staffing cover should be increased to adhere with RCOG / RCOA standards for safe anaesthetic provision.

The ERT also heard concerns in relation to obstetric workforce planning across all five HSC Trusts. Rota gaps, a reliance on locum cover and the curtailment of other clinical and non-clinical activities to ensure safe delivery suite cover was widely reported. Lack of fully staffed separate planned Caesarean birth lists was the norm in many HSC Trusts, with elective surgery being paused to accommodate emergency cases; all of which has obvious implications for patient experience and patient safety.

With the exception of the Belfast HSC Trust, which has separate units and rotas for obstetrics and gynaecology, HSC Trusts operate combined obstetrics and gynaecology rotas with one consultant covering both obstetrics and gynaecology out of hours. This is not unusual since separate rotas can be challenging to implement given the limited availability of trained obstetricians and gynaecologists. The Ockenden Inquiry recommends that, "In trusts with no separate consultant rotas for obstetrics and gynaecology, there must be a risk assessment and escalation protocol for periods of competing workload [which] must be agreed at board level". We found no evidence of such a formal process; instead there was found a heavy reliance on team support and good will. Nonetheless, where there are safety concerns this should be given due consideration. The ERT heard in one HSC Trust how a combined rota posed particular challenges given that emergency theatres for gynaecology were located a considerable distance from the delivery suite.

<i>Recommendation 7</i>	<i>Priority 1</i>
7.1 DoH / SPPG should consider liaising with RCOG to extend the 'Safe Staffing in Maternity Tool' to include HSC Trusts in Northern Ireland.	
7.2 SPPG and HSC Trusts should work together to review the capacity and capability of obstetric and anaesthetic teams to safely deliver maternity care out of hours.	
7.3 Commissioners and HSC Trusts should ensure that there is adequate on site 24/7 anaesthetic cover to enable immediate attendance of anaesthetists to emergencies on delivery suite.	

3.3.5 Non-clinical responsibilities of consultants

Unfortunately, the difficulties for consultant staffing were not limited to the availability of on-call cover. A recurring theme across HSC Trusts was the significant workload placed on consultant obstetricians impacting on their day to day work, particularly in relation to the undertaking of important non-clinical duties. The ERT heard from

consultants in a number of HSC Trusts who had been required to assume additional responsibilities without the appropriate time or administrative support to do so. The ERT also identified variation across HSC Trusts in the number of Programmed Activities allocated for leadership and governance responsibilities; in some cases, consultants reported performing two or three additional roles without receiving sufficient sessional time within job plans. The resulting impact on morale was evident to the ERT who considered that, in addition to staff wellbeing costs, the increased demands placed on consultant staff were such that they were likely to impact on their ability to effectively execute their duties. The ERT was concerned that leadership and governance roles were not given their due recognition by way of providing time and support to those undertaking them.

Non-clinical work provided by consultant staff plays a vital role in ensuring good governance and service improvement; workforce planning should take account of these necessary roles and of the administrative support required to undertake them. Regional agreement on the minimum allocation of PAs for such roles would be beneficial; HSC Trusts can subsequently supplement with additional PAs in accordance with local requirements, acknowledging that workload and work complexity can vary across units. In some units, the workload generated by specific leadership and governance roles may be such that the existing consultant body is unable to provide these in addition to direct clinical care requirements; where this occurs, the number of consultant posts should be expanded to ensure the provision of a safe service.

Recommendation 8	Priority 2
8.1 DoH / SPPG and HSC Trusts should work together to determine the minimum allocation of programmed activities (PAs) for specific leadership and governance roles within consultant obstetrician job plans.	
8.2 Each HSC Trust should ensure there is appropriate time available, provided as funded programmed activities (PAs), to facilitate the undertaking of leadership and governance responsibilities, appropriate to their local Trust context. Sufficient administrative support should also be provided.	
8.3 Where required, HSC Trusts should work with commissioners to expand the number to consultants to enable the required delivery of both clinical and non-clinical work to support safety within maternity services.	

3.3.6 Consultant Job Planning

Consultant job plans set out the duties, responsibilities and objectives for consultants for the year ahead along with the support and resources to be provided. Whilst they are an annual agreement between individual consultants and their employer, individual

consultant objectives should be determined within the collective objectives of specialty teams⁶¹. Effective systems for job planning serve to deliver appropriate allocation of clinical and non-clinical sessions across consultant teams in a way that supports fair distribution of workload, improves efficiency and meets the needs of the patient population.

The arrangements for job planning were deemed to be insufficient by the ERT who noted that consultants across a number of HSC Trusts had not been supported by annual job planning processes in line with employers' contractual obligations. A failure to conduct regular job planning for consultants represents a missed opportunity by HSC Trusts to ensure that consultant work plans align with organisational objectives, represent value for money and achieve positive patient outcomes.

The ERT recognises that resource, time, pandemic and post-pandemic pressures may have impacted on the ability of HSC Trusts to undertake job planning for their medical workforce, but deem it to be important in underpinning safe and effective maternity services which utilise the skills and experience of consultant staff. In order to assist HSC Trusts to fulfil their contractual obligations, the ERT recommends that investment in electronic job planning software should be considered. Electronic systems have been used elsewhere in the UK to reduce the administrative burden associated with job planning processes and to effectively harness the use of data to demonstrate service demand and capacity and highlight where changes to job plans are required⁶². One HSC Trust reported using Allocate Software to support job planning for senior medical staff.

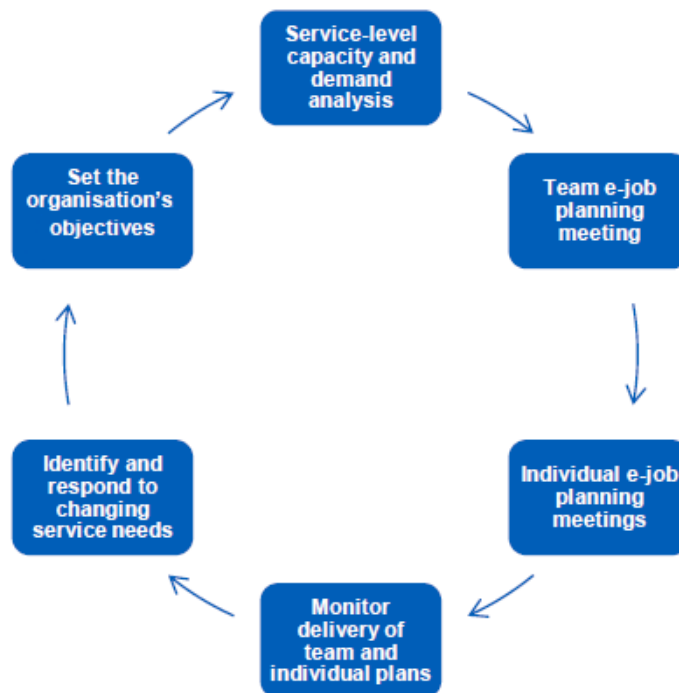


Figure 2. Six steps for electronic job planning: Adapted from NHS England and NHS Improvement: E-job planning the clinical workforce September 2020⁶³

Recommendation 9**Priority 2**

- 9.1 Each HSC Trust should ensure that arrangements for job planning and appraisal are in line with contractual obligations and produce outputs that enable consultants to fulfil their roles and responsibilities and ensure maternity services meet the needs of the population.
- 9.2 HSC Trusts should consider the introduction of an electronic platform for job planning to enable appropriate allocation and distribution of clinical and non-clinical work across consultant teams.

3.3.7 Recruitment and Retention

Adequate recruitment and retention of clinical staff provides the backbone of a safe maternity service. Failure to recruit and retain staff in permanent and substantive posts creates instability in the workforce, drives over-reliance on the use of locum and agency staff and significantly increases expenditure.

All HSC Trusts reported effective arrangements for recruitment, with some reporting good progress in addressing midwifery vacancy rates; albeit, as is the case UK wide, many HSC Trusts continue to face considerable staffing shortages. Midwives within some HSC Trusts reported challenges in recruiting and retaining newly qualified midwives and midwifery students. The ERT considered that investment in high-quality student placements along with mentorship and strong clinical and educational support for newly qualified midwives would help to attract and retain midwifery staff; this is particularly important in areas that are less geographically desirable.

It was also reported that inflexible working hours and a lack of autonomy over decisions to rotate midwifery staff to different clinical areas could lead to staff leaving for jobs elsewhere or taking early retirement. Acknowledging that employers may not always be in a position to facilitate requests to reduce hours or work in specific areas, where it is feasible, granting such requests may serve to retain staff and reduce vacancy rates; a point worth considering given the proportion of the workforce who have caring responsibilities and are over the age of 55.

The older profile of the workforce was recognised to impact on retention across HSC Trusts with the 'retire and return' policy commonly cited as a useful mechanism to retain skilled and experienced staff. Some HSC Trusts referenced additional support provided to help people return to work after a period of absence including retirement; the ERT considered this to be good practice.

When staff leave or retire from a service this requires backfilling and further recruitment. A robust approach to succession planning can alleviate pressures that

are created when posts need to be filled urgently. All HSC Trusts reported succession planning for midwives yet this was less evident for medical staff. This can pose additional challenges when consultants retire early as there can be a loss of skill and experience that is difficult to replace internally and recruitment processes for substantive posts can be protracted.

A number of HSC Trusts reported recent expansion of consultant teams. However, some HSC Trusts reported ongoing difficulty with recruitment into consultant posts, which they attributed to geographical reasons and the availability of consultant posts elsewhere. In one HSC Trust, the ERT was informed that recent difficulty in recruiting and retaining consultant obstetricians was due to the Trust's reputation for a persistent blame culture.

One HSC Trust raised the issue of suboptimal trainee allocation to the Trust from NIMDTA's Obstetrics and Gynaecology Specialty Training Programme. This was said to be posing challenges for staffing the junior medical rota impacting on both training opportunities and service delivery. Difficulties recruiting O&G trainees at a regional level was cited as a matter of concern as this will have a direct impact on the numbers of Northern Ireland-trained O&G consultants going forward, a problem further compounded by a UK-wide shortage of qualified obstetricians and gynaecologists.

3.3.8 Maintaining safe staffing levels

Delivering services without a full complement of staff presents significant challenges for patient safety. For this reason, gaps in rotas require to be filled. Across HSC Trusts, vacant posts and shifts are commonly filled by locum and agency staff. Spend on locum and agency staff comes from non-recurrent Trust funding, where as permanent posts are funded through recurrent funding.

HSC Trusts reported spending large sums on locum / agency cover. During the financial year 2021 – 2022, HSC Trusts collectively spent just over seven million pounds^{xiii} on locum and agency shifts for HSC maternity services alone. Whilst this is an enormous expenditure, it is acknowledged that such costs may be essential in the short term in order to maintain a safe service. However, it is important to note that locum and agency staff should have a robust assessment of skills and competencies prior to commencement and may require extensive support through induction, clinical supervision, mentorship and training⁶⁴; all of which is resource intensive and may have time-limited benefits in those circumstances where staff have short term locum contracts.

^{xiii} This figure reflects the spend across all five HSC Trusts and was calculated based on information returned to RQIA by each of the HSC Trusts.

Where possible, the ERT considers that, given the significant costs of locum / agency staff and additional support required to ensure safe practice, a sensible approach would be to convert non-recurrent to recurrent funding to enable an increase in the number of substantive and permanent posts and improve stability of the workforce in the longer term. At least one HSC Trust expressed a desire to adopt this approach however the ERT was informed that such a move was outside the HSC Trust's control.

Recommendation 10

Priority 1

DoH / SPPG should undertake an evaluation of non-recurrent spending on agency and locum staff within HSC maternity services and should consider converting non-recurrent to recurrent funding to increase the number of substantive posts to enhance capacity, stability and resilience within HSC maternity services.

3.3.9 Escalation arrangements

In the current climate of high staff absence rates across HSC services, it is essential that there are robust mechanisms to monitor staffing levels and to implement escalation plans when staffing falls below safe levels.

All HSC Trusts had a safe staffing escalation policy and evidenced sufficient staffing escalation arrangements, with some HSC Trusts conducting daily huddles to monitor activity and acuity, and allocate staff accordingly. Despite these arrangements, the pressures remain significant and the resulting impact on staff wellbeing is likely to have a perpetuating impact as high levels of burn out and stress lead to further sickness absence. This is corroborated by the results of our Maternity Safety Culture Staff Survey where just 16.4% of staff agreed with the statement, "We have enough staff to handle the workload". Qualitative analysis of survey responses was suggestive of a high prevalence of burn out and work-related stress linked to staffing shortages.

During site visits, the ERT heard from midwifery staff across HSC Trusts who described how being 'pulled' from other clinical areas to support delivery suite was unsettling for the staff redeployed at short notice and stressful for midwifery staff who were left behind on the wards, sometimes with unmanageable workloads.

It was reported to the ERT that the current escalation arrangements for calling in additional staff from home were increasing staff stress and significantly impacting on their mental wellbeing. Across HSC Trusts, WhatsApp groups were utilised to deliver 'SOS' messages and rally midwifery staff at short notice. The use of such groups has arisen during the pandemic as a convenient means of contacting staff to ask for urgent support with cover. Whilst more responsive than traditional bank rostering systems, the ERT considered that such informal messaging systems are, by their nature, less contained and overly intrusive on the lives of those who are off duty. Numerous staff

reported increased anxiety as a result of receiving 'SOS' messages; some reported dread at coming on duty knowing in advance how busy it was and others reported feeling guilty at not being able to help their colleagues who they knew were facing challenging working conditions. The ERT considered that the additional stress caused by 'SOS' messages is avoidable and that HSC Trusts should improve systems for staffing escalation to take into account of their impact on staff wellbeing and allow effective 'down time' for staff to recuperate while off duty.

Recommendation 11

Priority 1

Each HSC Trust should review their arrangements for staffing escalation and should ensure that the measures used to roster additional staff at short notice are sensitive to their wellbeing needs. In particular, HSC Trusts should engage with staff to explore suitable alternatives to 'SOS' WhatsApp groups.

3.3.10 Supporting staff wellbeing

The challenges presented by the COVID-19 pandemic have drawn into sharp focus the need to better support the healthcare workforce. Due to the nature of the work, front line maternity services can be high-pressured, stressful environments even when working conditions are at their optimum. Therefore, it is all the more important that staff are supported in the current climate when workload, acuity and complexity are at an all-time high. Failure to support staff appropriately can increase incivility and burn out; both of which can be detrimental to staff wellbeing leading to impaired performance, increased sick leave and poor staff retention rates. Above all, these are patient safety issues that require to be addressed by a multi-level commitment to improving workplace culture whilst strengthening the systems that support staff to do their job well.

It was highlighted to the ERT across HSC Trusts that due to heavy workloads, working environments were not favourable for staff wellbeing.

The ERT was informed that the development of the midwifery role, in line with the NMC standards of proficiency for midwives, has impacted on midwifery workloads. Whilst midwives welcomed the opportunity to upskill and provide enhanced care to women and babies, some expressed a concern that more was being demanded of midwives than they had time to safely provide in the current context of significant workforce challenges.

In one HSC Trust, it was reported that midwives faced additional workload pressures due to midwifery provision of ultrasound scanning in the maternity assessment unit. The ERT considered that a reliance on doctors and midwives to perform antenatal ultrasound scans is a feature of maternity care that is unique to Northern Ireland and

not seen in other parts of the UK, where routine antenatal scanning is undertaken by trained sonographers.

In a number of HSC Trusts, midwives reported that they had chosen to work part-time as the workload was such that full-time work was not physically or emotionally sustainable; many reported burn out and work related stress experienced from working shifts where, due to staffing shortages, they were unsupported to care for numerous patients, some of whom had additional complexity. In one HSC Trust, midwives described adverse working conditions where midwives were unable to take their breaks and may have to look after more than one woman at a time on delivery suite. The ERT considers that these conditions are not conducive to patient safety and more needs to be done to support midwives working in such difficult circumstances.

Supporting healthcare professionals begins the moment they walk through the door. Robust induction arrangements and mentorship can help to support staff as they adjust to the demands of their new role. All HSC Trusts reported appropriate arrangements for induction of midwifery staff and obstetric trainees; this was less commonly reported for consultant staff. Whilst supervision and support provided to O&G trainees was reported to be good across most HSC Trusts, mentorship for newly qualified consultants did not appear to be common place.

Each HSC Trust cited support provided to newly qualified midwives through preceptorship programmes. During fieldwork across HSC Trusts, the ERT heard that the delivery of preceptorship programmes was dependent on staffing and, as such, can be inconsistently implemented. In one HSC Trust, midwives highlighted that educational, clinical and mentorship support provided to newly qualified midwives was insufficient and had led to the loss of capable and talented staff members.

The ERT heard that in some HSC Trusts, junior midwives, due to suboptimal support early in their careers, lacked confidence in skills such as intravenous cannulation and perineal suturing and had to rely on the support of colleagues to provide these elements of care. Similarly, consultant obstetricians reported that since the COVID-19 pandemic, consultants had become the default to deal with issues where other staff were unavailable or lacked confidence; this could mean undertaking duties normally performed by junior colleagues. Significant consultant workloads were said to be contributing to burn out and poor morale.

Supporting staff during the course of their working life involves providing professional support and fostering a spirit of collegiality; these can be lacking in working environments where there is bullying, undermining and incivility. Bullying and undermining can be a particularly insidious problem contributing to burn out, a fear of raising concerns and mental ill health⁶⁵; whilst incivility has been demonstrated to reduce team functioning, affecting clinical decision making and patient outcomes⁶⁶. Counteracting this requires strong leadership; promoting a culture of psychological

safety, civility and teamwork, whilst ‘calling it out’ and swiftly addressing behaviours when witnessed. These approaches should be underpinned by clear procedures for dealing with bullying and mechanisms for supporting those impacted. Nationally, these are prevalent problems within maternity units and Northern Ireland is no different.

The Maternity Safety Culture Staff Survey found that just 36.3% of staff across the region agreed with the statement, “Bullying and undermining behaviours are dealt with effectively”; 75.7% agreed with the statement, “Staff are kind and civil to each other”. Qualitative analysis of free text responses found reports of bullying, undermining and incivility across all HSC Trusts, albeit to varying degrees. During fieldwork, we heard examples of O&G trainees experiencing undermining when seeking consultant advice and at consultant-led handovers. In one HSC Trust, the ERT heard that O&G trainees felt undermined when midwives bypassed them in favour of a more senior opinion.

It was noted that not all HSC Trusts provide training to managers and clinicians on issues such as civility and psychological safety and how they impact on staff wellbeing and patient safety. The ERT considers that all HSC Trusts should ensure clinical and management-level staff from ground level up to the Trust Board receive training on these important patient safety issues.

All HSC Trusts reported systems to support staff when wellbeing issues arise; these comprised access to occupational health, counselling and psychology services. However, not all HSC Trusts reported having preventive mechanisms in place to support staff wellbeing and mitigate stress with a view to reducing the incidence of staff illness. Whilst all HSC Trusts provided support for staff involved in SAIs, only three HSC Trusts had embedded mechanisms such as Schwartz rounds to support staff with the emotional aspects of their work in a way that is not restricted to the aftermath of an incident. The ERT considers that all HSC Trusts should adopt a proactive approach to staff wellbeing rather than waiting until problems emerge; such an approach might involve: regular Schwartz rounds, peer support, and counselling.

Recommendation 12

Priority 2

- 12.1 All HSC Trusts should ensure that clinical and management-level staff within maternity services receive training on human factors, psychological safety and civility.
- 12.2 Each HSC Trust should implement proactive approaches to supporting staff wellbeing for all maternity staff groups. This should include: adequate induction, mentorship programmes and mechanisms, such as Schwartz rounds and other forms of peer support, to support staff with emotionally challenging aspects of their work; augmented with access to counselling, as required.

3.4 Systems for safe, effective and compassionate care

3.4.1 Staff training

Robust arrangements for training maternity staff are essential to ensuring that staff have the requisite skills and competencies to perform their role and deliver a safe service. This requires the delivery of mandatory training to all staff groups supplemented by regular ongoing multidisciplinary teaching to maintain skills in areas such as cardiotocograph (CTG) interpretation and obstetric emergencies.

Mandatory training requirements are largely determined at HSC Trust level. Although the regional HSC Learning system provides a route by which online training modules can be accessed by staff in all HSC Trusts, individual HSC Trusts have bespoke requirements and arrangements for delivery of mandatory training. Furthermore, there is no formal regional agreement on the minimum training requirements for staff to work within HSC maternity services.

The Ockenden Report rightly recommends that, “Staff who work together must train together”. Multidisciplinary training carries benefits that extend beyond the learning of skills and competencies. Fostering a multidisciplinary understanding of decision making in complex cases and learning from difficult or adverse events can assist in building relationships across clinical teams.

HSC Trusts described arrangements for multidisciplinary education and training. Whilst all HSC Trusts provided Practical Obstetric Multi-Professional Training (PROMPT) training, there was variation in the disciplines attending, with not all HSC Trusts including anaesthetists and neonatologists as participants. Encouragingly, one HSC Trust provided MDT training that included Northern Ireland Ambulance Service (NIAS) paramedics in recognition of a changing landscape in respect of home births and ambulance transfer times.

Many HSC Trusts supplemented PROMPT training with regular multidisciplinary ‘skills and drills’ training; which is useful, not just in maintaining obstetric emergency skills, but also in testing local protocols to identify areas for improvement. Some HSC Trusts also reported utilising more innovative means to deliver teaching and training such as simulation training and a ‘Tea Trolley’^{xiv} teaching initiative.

The ERT considers that initiatives which maximise opportunities to train staff are valuable and can be strengthened through the use of a co-ordinated approach to

^{xiv} The Tea Trolley Training is a QI initiative offering the opportunity for MDT to share learning, less formally, over a cup of tea.

deliver multidisciplinary training where topics and learning objectives are aligned to themes that are identified through maternity governance systems; the Southern HSC Trust has successfully implemented such an approach.

Good Practice Example: Southern HSC Trust Education and Training

The Southern HSC Trust has adopted a co-ordinated safety-focused approach to multidisciplinary teaching which is attended by all relevant staff groups including: medical staff, midwives and midwifery support workers.

The Midwifery Practice Education Team takes the lead on ensuring that topics are aligned to quality and safety concerns arising from a range of sources including: service user feedback; complaints; Datix / incidents; SAls; coroner cases; litigation cases.

The learning from these is examined across three dimensions comprising:

- clinical skills;
- human factors;
- systems thinking.

Learning objectives are derived and may include: communication, teamwork, escalation, psychological safety and accountability.

Teaching is then delivered by the Education Team Hub across a number of modalities:

- Skills and drills;
- Simulation training;
- Face to face training;
- Monthly topic in focus;
- CTG teaching.

The Southern HSC Trust has also held a series of Saving Babies Lives Study Days attended by staff from all relevant specialty groups.

As a region, Northern Ireland has adopted physiological CTG interpretation which requires maternity staff to have an in-depth understanding of both normal and abnormal fetal heart rate responses during pregnancy, labour and birth. This represents a shift away from the former method of interpreting CTGs according to the classification approach set out by NICE. Whilst all HSC Trusts have endorsed physiological CTG interpretation, only three appear to have successfully embedded it to date. One HSC Trust reported challenges due to a lack of funding for a CTG midwifery post.

Some HSC Trusts cited barriers to the delivery of training due to COVID-19 pandemic, with both the capacity of staff to facilitate and attend being impacted. However, clinicians in one HSC Trust highlighted a positive impact arising from the ability to host virtual meetings, which through improved accessibility has increased attendance at teaching sessions. Time to attend both in-house and external training was repeatedly referenced across HSC Trusts as an issue and whilst most staff felt supported by the Trust to avail of study leave or attend courses, it was not feasible in the current context of staffing shortages and service delivery pressures. Furthermore, not all HSC Trusts offered protected time for multidisciplinary education and it was not uncommon for sessions to be cancelled at short notice due to the need to deploy staff to clinical settings. Clinicians in one HSC Trust stated that, in addition to time constraints, a lack of space and equipment has significantly hampered the delivery of in-house training; the ERT considers that these practical elements need to be addressed.

All HSC Trusts reported systems for oversight and monitoring of mandatory training for midwives. Most HSC Trusts reported using an electronic system such as e-roster or Sharepoint. Whilst service level arrangements for monitoring the mandatory training of midwives were found to be satisfactory, the arrangements for monitoring mandatory training of medical staff were considered by the ERT to be inadequate. Although one HSC Trust cited the use of a 'training passport' system for medical staff, most HSC Trusts reported using the appraisal process as a means of monitoring completion; appraisals function as a private conversation between an appraiser and an appraisee and the regional appraisal system does not facilitate oversight of completion rates across medical staff groups. Furthermore, the ERT found that arrangements for oversight of mandatory training for all staff groups at Trust Board level required strengthening and there was no evidence that key performance indicators in relation to completion were shared or collated centrally at the level of DoH / SPPG.

Recommendation 13	Priority 2
<p>13.1 All HSC Trusts should ensure that there are robust arrangements for the delivery of training for maternity staff, which includes protected time for multidisciplinary attendance, and adequate space and equipment.</p> <p>13.2 DoH / SPPG, HSC Trusts, Royal Colleges (RCOG, RCM) and the Maternity Collaborative should work together to determine the minimum training requirements for staff working within HSC maternity services. Mandatory training completion rates for maternity staff groups should be collated as a performance metric and monitored by the Trust Board and commissioners.</p>	

3.4.2 Evidence-based practice

Clinical effectiveness is a core component of safety within maternity services and requires that clinical practice is standardised and based on the best available evidence. National and regional guidance from bodies such as NICE and RCOG sets out relevant service and clinical practice standards. Non-adherence to clinical guidelines poses challenges for the consistent delivery of safe effective care; for this reason, deviation from standard practice should only occur for justifiable reasons, the rationale for which should be fully documented, and should be discussed at consultant level. Recent inquiries into NHS maternity services have highlighted the harms that occur when there is deviance from evidence-based practice. It should also be noted that a key regional recommendation from the Independent Neurology Inquiry is that “Healthcare organisations should make it clear to clinicians that they are expected to follow national and local patient management guidelines”. Maternity services, like all HSC services, should have robust arrangements to ensure that local policies and guidelines are up to date and that practices within the service comply with regionally endorsed guidance and best practice Royal College standards.

All HSC Trusts outlined arrangements for updating clinical guidelines. One HSC Trust acknowledged ongoing challenges in this area, which were previously highlighted through an RCOG Invited Services Review. The ERT considered that whilst some HSC Trusts demonstrated satisfactory arrangements with appropriate oversight and multidisciplinary involvement, in many HSC Trusts these were hampered by a lack of time within consultant obstetrician job plans for the undertaking of governance roles, meaning that guideline development was heavily reliant on the input of midwifery staff and progress often delayed by a lack of timely obstetric involvement. The ERT considers that HSC Trusts should ensure robust arrangements for developing, reviewing and updating guidelines; these should be supported by appropriate multidisciplinary input and oversight at a maternity governance level.

In Northern Ireland, national and regional guidelines are endorsed by DoH. A number of regional guidelines have been developed by Guidelines and Audit Network (GAIN) and RQIA in relation to HSC maternity services^{67,68}. Following a witness testimony at a coroner’s inquest in 2022, the Department of Health reviewed the GAIN guideline for admission to midwife-led units (MLUs) in Northern Ireland (2016, updated 2018) and the RQIA Guideline for planning to birth at home (2019) against the extant Department endorsed NICE CG190 guidance on intrapartum care for healthy women and babies (endorsed January 2015)⁶⁹. DoH’s review identified a number of discrepancies which it determined posed a potential risk to patient care. On 21 November 2022, DoH issued a circular (HSS (MD) 52/2022)⁷⁰ to RQIA and HSC Trusts to advise that the GAIN and RQIA guidelines were withdrawn and to re-emphasise the importance of ensuring the implementation of NICE CG190 guidance.

During fieldwork sessions with management staff and clinicians across the five HSC Trusts, concerns were raised regarding the withdrawal of these GAIN and RQIA guidelines. The ERT heard consistent views across all HSC Trusts that this withdrawal has created a gap in guidance that is not sufficiently filled by the NICE guidelines which do not reflect local arrangements here in Northern Ireland. Staff explained that the GAIN and RQIA regional guidelines were evidence-based, co-produced, based on local data and intended to be used in conjunction with, and not instead of, NICE guidance.

Furthermore, it was highlighted to RQIA that the GAIN guidance for admission to MLUs was endorsed by the European Midwives Association and had been adapted for use in other parts of the UK. The sense that a void had been created was reported to be causing anxiety amongst midwifery staff who seek to provide individualised decision-making support to women regarding place of birth based on local arrangements. The ERT considers that a balanced approach might include the review and updating of guidance and that this should be accompanied by careful engagement with clinicians and Royal Colleges to seek and listen to views and address concerns. The ERT deems this to be important as the perceptions of a void, real or otherwise, could lead to variation in practice across HSC Trusts at a time when more women are requesting home births and care outside guidance.

Recommendation 14

Priority 2

14.1 Each HSC Trust should ensure there are robust arrangements for developing, reviewing and updating local guidelines, policies and protocols. HSC Trusts should ensure an appropriate level of multidisciplinary involvement and oversight by local maternity governance groups.

14.2 DoH / SPPG should work with PHA, all HSC Trusts, RCM, RCOG and service users to ensure there is clear up-to-date guidance on the regional arrangements for admission to midwifery led units and choosing to birth at home.

3.4.3 Supporting informed choices and person centred care

Supporting decision-making in pregnancy requires robust risk assessment and the provision of unbiased information so that women can make fully informed choices. This includes choices around place and type of birth. Pregnancy and birth are normal physiological processes which most often result in a healthy baby. However, they are not without risk, and intervention may be required for obstetric reasons. Following risk assessment, all women should be counselled appropriately on the birthing options available to them including pain relief, the need for monitoring, risk of complications and of requiring obstetric intervention during labour and birth. This will inform the

woman's decision-making around type and place of birth ensuring that her choices are fully informed.

Informed consent has been topical since the 2015 Montgomery Vs Lanarkshire ruling, a landmark case which stipulated that patients should be given information on all material risks⁷¹. All HSC Trusts reported providing training to staff on informed consent principles, supported by the provision of unbiased patient information materials on the benefits and risks associated with differing types and places of birth.

Undoubtedly, there remain societal pressures for women to achieve normality in pregnancy and birth. It is important to note that 'normalisation' of birth is no longer promoted as a national standard^{72,73}, and the objective of maternity care should not be to achieve a 'normal' or vaginal birth, but a safe birth; as was further highlighted in the most recent Kirkup report⁷⁴. Whilst safe births often require intervention, caution should also be exercised to ensure providers do not inadvertently increase risk, and service pressures, through unnecessary intervention; for these reasons, adherence to evidence-based clinical guidance is important.

3.4.4 Care outside guidance

Although HSC Trusts and clinicians should endeavour to ensure that practice is evidence-based, some women may choose not to follow the recommended care pathways set out in national standards. An increasing number of women, with known risk factors where NICE guidance recommends birth in an obstetric unit, are now opting to give birth in other settings; it is important that the autonomy of all women is respected whilst providing full and unbiased information to support their decision making. The PHA, in collaboration with clinicians across the region, recently developed a draft 'Regional framework for health care professionals who support women who request care outside guidance in Northern Ireland'. It is intended this will be issued in 2023; publication has been delayed due to the unexpected withdrawal of GAIN and RQIA guidelines.

During fieldwork, the ERT explored arrangements for counselling and supporting women who seek care outside guidance. The ERT heard from clinicians about the challenges for midwives in supporting women who wish to give birth at home but who are recognised to be at higher risk of complications during labour and birth. Community midwives reported feeling vulnerable and anxious providing care in circumstances where complexity may increase the chance of adverse events; this anxiety was said to have increased following withdrawal of RQIA guidelines and whilst awaiting publication of the PHA care outside guidance framework to underpin their practice in relation to counselling and supporting women with decision-making.

Clinicians reported that the closure of freestanding midwifery led units has led to an increase in the number of women seeking home births and that there have been

reports of a small number of ‘free births’ occurring in the region, where women choose to birth without midwifery assistance. Sadly, this has led to poor outcomes. The ERT also heard from community midwives who had been actively prevented from attending a home birth by the woman and her attendants; the midwives retold how vulnerable and anxious they felt in case they would be criticised if there was a poor outcome.

The ERT considers that all women should be appropriately counselled regarding place of birth and should be supported with fully informed decision making when they seek care outside guidance; this should involve the provision of information on risk including ambulance transfer times, which are increased in the current climate. Women’s autonomy should be respected and women should feel supported to change their birth plan, should they change their mind about place of birth at a later stage. Community midwives delivering care to women who choose to birth outside guidance should also feel supported by up to date processes and robust arrangements.

Recommendation 15	Priority 1
<p>15.1 Each HSC Trust should ensure there are robust arrangements for counselling and providing care to women who seek ‘care outside guidance’. Arrangements should utilise a partnership approach that respects women’s autonomy whilst supporting decision making that is fully informed ensuring women are provided with all relevant information on risk, including information on ambulance transfer times.</p> <p>15.2 Each HSC Trust should ensure that there is sufficient support and guidance for midwives and obstetricians who are required to support women who choose ‘care outside guidance’.</p>	

3.4.5 Person centred care for women with social complexity

Inequality through social deprivation and multiple disadvantage is increasing across the UK and is likely to be exacerbated in the current socio-economic climate. Women with social complexity or vulnerability factors may face barriers to accessing services and are known to be at higher risk of adverse outcomes including perinatal and maternal mortality. ‘MBRRACE-UK Saving Lives, Improving Mother’s Care 2022’ reported that women from the most deprived areas are 2.5 times more likely to die during or after pregnancy than women from the least deprived areas⁷⁵. Where there are multiple vulnerabilities, the risk of adverse outcomes is even higher.

Compounding social deprivation, other vulnerability factors may include: history of adverse childhood experience, asylum seeker status, ethnic minority background, mental ill-health, substance use, domestic abuse, and learning disability. A lack of engagement with services from these groups is likely to reflect that their needs are not being met^{76,77}. Advocacy organisations reported that women disengage from services

when they find the language and terminology inaccessible, which includes not just women without English as a first language but women with low levels of educational attainment, and when maternity staff have not provided continuity of care or worked to build relationships based on mutual trust and respect. In the context of service pressures, maternity staff may not be afforded the necessary time to provide this level of individualised care; however, charities and advocacy groups have more time and play an important role ensuring the women's voices are heard and that their needs are identified and responded to. Therefore, it is vital that person centred pathways for women with social complexity are underpinned by multi-agency input that includes advocacy support.

Person centred care involves working in partnership with women to meet their medical, psychological and social needs, whilst treating them with compassion, respect and dignity. In the maternity context, it promotes engagement with antenatal services and improves outcomes for women and babies. Women with vulnerability factors are known to benefit from continuity of care by maternity staff who are skilled and experienced in managing social complexity⁷⁸. This requires allocation and training of staff along with robust mechanisms which safeguard women and children.

All HSC Trusts described pathways for social services involvement and links with voluntary sector groups such as Women's Aid for women experiencing domestic abuse. There was variation in availability of specialised antenatal care for women with social complexity. Most HSC Trusts had antenatal clinics for women with social complexity, who require social services involvement; these clinics were also attended by women with perinatal mental health problems.

The Belfast HSC Trust has a dedicated team of SWAN (Social Wellbeing and Antenatal Complexity) midwives who are skilled and experienced in looking after women with social vulnerability factors. They build relationships with women, provide care continuity and enhanced support throughout the pregnancy and early postnatal period. However, we heard that not all HSC Trusts have sufficient resource allocated to meet the needs of the vulnerable patient population and even when there is resource available, recruitment can be an issue. One HSC Trust reported that a specialist midwife post was vacant at the time of fieldwork.

The ERT heard concerns that even when existing maternity pathways are resourced and provided as intended, enhanced support for vulnerable women is discontinued too soon in the postnatal period. This is particularly short sighted when one considers how crucial the first year of life is for child development and long term health outcomes. Furthermore, women with multiple adversity are at increased risk of suicide, which remains a leading cause of maternal death UK-wide. In the Belfast HSC Trust area, there is a high level of social deprivation. In the past five years, amongst women who had attended the SWAN clinic during pregnancy, there have sadly been 17 deaths within one year of giving birth. These include deaths caused by suicide, drug overdose,

and domestic homicide; many are noted to have occurred outside the six-week postnatal period.

The ERT considers that in order to improve maternal and child outcomes, pathways of support for women with vulnerability factors should be extended and should include co-ordinated multi-agency input from both HSC and the voluntary sector. This may include agencies such as community midwifery teams, social services, health visitor services, perinatal mental health services, Family Nurse Partnership and Sure Start. Given the increasing social complexity amongst the maternity population, postnatal support pathways should be considered as part of any new maternity strategy.

3.4.6 Providing safe care to ethnically diverse women

‘MBRRACE-UK Saving Lives, Improving Mother’s Care 2022’ reported that black women were 3.7 times more likely to die during or after pregnancy than white women. Asian women were 1.8 times more likely to die⁷⁹. Whilst ethnicity should not be conflated with deprivation, ethnically diverse women are more likely to have intersecting vulnerabilities which increases the risk of adverse maternal and neonatal outcomes.

During our engagement with advocacy groups we heard that migrant women due to language barriers, cultural differences, and a lack of staff training, can struggle to get their needs identified and met by maternity healthcare providers. We also heard of asylum seeking women, many of whom have experienced significant trauma prior to entry to Northern Ireland, being housed in accommodation such as ‘asylum hotels’ that are unsuitable for pregnant women and new born babies. Advocacy groups reported that migrant women, feared being charged for maternity services and that this was driving some women to book late in their pregnancies or to birth without medical assistance. Under the current legislation, Health and Personal Social Services Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015, women who are deemed to be a chargeable visitor^{xv}, may be required to pay for HSC maternity care. Operational guidance states that “no woman must ever be denied, or have delayed, maternity services due to charging or payment issues”⁸⁰. Nonetheless, seeking payment from women who are least likely to be able to afford maternity care represents an unacceptable structural barrier that needs to be addressed UK wide⁸¹.

^{xv} A chargeable visitor is a person not ordinarily resident in the United Kingdom.

All HSC Trusts described access to interpreting services for women where English is not their first language. This took the form of face-to-face interpreters and also access to Big Word. With the exception of interpreting services, there was variation in the level of enhanced support available for women from outside the UK. This was recognised by clinicians as an area which requires attention; midwives in one HSC Trust described the additional safeguarding challenges that had been presented by a rise in the number of women with female genital mutilation (FGM), reflecting an increase in the number of migrant women to the local Trust area.

The Southern HSC Trust has a large number of women from East Timor, a population known to have a significantly increased risk of obstetric complications compounded by non-engagement with maternity services. Southern HSC Trust has put in place specific arrangements for the antenatal care of these women which the ERT consider to represent good practice. Furthermore, Southern HSC Trust also has midwifery representation at HSC Trust meetings with members of the travelling community; the ERT considers that this may help to decrease perceived stigma and increase engagement with maternity services.

Whilst all HSC Trusts offered training to staff, there was variation in the type of training provided. All HSC Trusts require staff to have Equality and Diversity training, which although important, is not sufficient to train staff on health inequalities encountered within the maternity setting. Two HSC Trusts described additional training provided to staff such as 'Cultural Competence and Safety Workshop' and Human Rights training. The ERT considers that given the significantly increased risk of morbidity and mortality identified through MBRRACE-UK, all HSC Trusts should invest in training for staff for women with social complexity or vulnerability factors, including migrant women.

Recommendation 16

Priority 3

16.1 Each HSC Trust should ensure that there are person-centred maternity pathways for women with social complexity. Each HSC Trust should provide training to maternity staff on how to reduce inequalities and provide support to ethnically diverse women and women with vulnerability factors.

16.2 DoH / SPPG / PHA and HSC Trusts should work together to enhance and extend the provision of postnatal support provided to women and babies with social complexity. This should include co-ordinated multi-agency input from a range of HSC and third sector organisations; such as community midwifery teams, social services, health visitor services, perinatal mental health services, Family Nurse Partnership and Sure Start.

3.4.7 Systems in place to support patient safety

Ensuring safety within maternity services requires effective systems and processes to support positive outcomes for women and babies, and reduce risk. Such systems may include arrangements for handover, safety briefs / huddles, scheduling elective births and patient transfer. Processes may involve the use of standardised checklists, risk assessments and proformas.

Handover is a well-established mechanism for communicating information between clinical teams who are changing over between shifts. It supports continuity of care and maintains situational awareness of the unit as a whole. Effective handover is crucial as omissions and inaccuracies in the sharing of information can lead to patient harm. All HSC Trusts described robust arrangements for handover, with the exception of one HSC Trust which stated that on some days there can be four handovers between consultant-led obstetric teams on delivery suite. The ERT considers that this represents a substantial gap in continuity of care that needs to be addressed.

All HSC Trusts reported using daily safety briefs to communicate and address risks at an operational level. One HSC Trust also utilised the Charles Vincent Framework for measuring and monitoring safety on a day to day basis. The ERT considered that this represents good practice.

Managing the day to day workload within maternity units requires effective systems and pathways to support safety. The ERT noted that in many HSC Trusts, the same clinical teams managed both the scheduled and unscheduled work, often within the confines of the same clinical area. This was highlighted as presenting significant challenges for the delivery of timely care and patient flow.

Staffing pressures combined with difficulties in managing the volume, complexity and acuity of unscheduled maternity care, pose additional challenges for managing scheduled work such as inductions of labour and planned caesarean births, which were often delayed due to competing pressures. The ERT heard about challenges in all HSC Trusts in providing adequate numbers of staff to manage elective births and in ensuring patient flow through delivery suites. Some HSC Trusts had high numbers of women undergoing inductions and planned caesarean births without the provision of dedicated elective teams to look after them. In one maternity unit, the lack of an additional theatre on delivery suite created ongoing difficulties; plans were in place to convert a room into a second theatre but funding had not yet been allocated. The ERT considers that this should progress without delay.

Inevitably, all these difficulties create delays; and delays in births which are planned for maternal or fetal reasons increase the risk of poor outcomes. Effective risk mitigation involves managing workload through reduction of unnecessary intervention, in conjunction with robust systems for risk assessment and prioritisation of clinically

indicated cases. In one HSC Trust, the ERT heard how the systems for prioritising elective induction of labour and caesarean births often relied on limited clinical information with inconsistent consultant input; this had recently formed part of an internal whistleblowing investigation. Upon request, the HSC Trust provided assurances to RQIA that these concerns are urgently being addressed. Nonetheless, the ERT considers there is learning for all HSC Trusts in how to manage the scheduled workload alongside the demands of unscheduled work.

The ERT considers that all HSC Trusts should ensure that decisions and protocols for induction of labour and planned caesarean births, undertaken for clinical indications, adhere to national standards. Staffing models and clinical pathways for induction of labour and planned caesarean births should be designed to maximise outcomes and reduce risk. Where possible, there should be dedicated clinical teams available to provide care to women undergoing these interventions. Systems for prioritisation of cases should be supported by robust risk assessment and consultant oversight to ensure safety and mitigate risk created by delays. All HSC Trusts should ensure that patient flow is optimised through the delivery suite.

Recommendation 17	Priority 1
<p>17.1 Each HSC Trust should undertake work to improve pathways of scheduled and unscheduled maternity care to ensure safety; where this is not feasible within existing budgets, this should be escalated to commissioners.</p>	
<p>17.2 Each HSC Trust should ensure that staffing allocation, clinical pathways, systems for prioritisation and patient flow are optimised to maximise outcomes and reduce delays, specifically for women undergoing induction of labour and planned caesarean births.</p>	

3.4.8 Multidisciplinary approach to governance within HSC maternity services

Good governance within maternity services requires strong partnership working between obstetrics and midwifery at a senior level. The Ockenden Inquiry recommended that there should be joint responsibility and accountability for maternity governance systems at the level of the clinical director for obstetrics and director of midwifery, or equivalent. At a unit level, multi-professional working should underpin the systems for assuring quality and safety of care. These systems should support a holistic approach to assurance, seeking information from a range of sources to identify and manage risk, determine service-level safety priorities, and implement improvements.

Joint responsibility and a multidisciplinary approach to governance was evident across three HSC Trusts. However, in two HSC Trusts, the ERT considered that operational responsibility appeared to be heavily reliant on the input of the Clinical Risk Midwife.

Furthermore, in one HSC Trust, significant weight was applied to Datix reporting at the expense of other sources of information; the ERT considers that a broader perspective of governance strengthened by multidisciplinary involvement is required. In particular, greater obstetric involvement in governance is needed across all HSC Trusts; a factor which is presently hampered by insufficient PA allocation within consultant job plans.

At a unit level, multidisciplinary governance teams should have responsibility for overseeing a number of governance work streams comprising: guideline development; learning from incidents, mortality and morbidity, complaints, litigation, service user and staff concerns; and learning from external reports such as national inquiries and reviews. These should be used to identify key safety priorities and drive programmes of audit, quality improvement and staff education. Whilst a number of HSC Trusts demonstrated these elements, this was best exemplified by Belfast HSC Trust.

Good Practice Example: Belfast HSC Trust Learning and Improvement Group

The Learning and Improvement Group is a multidisciplinary maternity governance group, formerly known as the Excellence and Governance Group.

The purpose of the group is to derive learning from a range of sources in order to disseminate learning to the frontline and drive quality improvement.

The group is co-chaired by a Consultant Midwife and Obstetric Governance Lead. Its membership comprises the Collective Leadership Team, Service Manager, Consultant Midwives, Clinical Director, Governance Midwives, Quality and Governance Midwife, Chair of Stillbirth Working Group, Obstetric Governance Lead, Representation from ALERT, Directorate Planning and Performance Manager, PMRT Midwife, Representation for Neonatology, Governance Lead for Neonatology. Others attendees are invited as required by agenda or specialist interest.

The group meets monthly to consider:

- Trend and theme analysis from complaints;
- Trend and theme analysis from adverse incidents;
- Learning from serious adverse incidents;
- Perinatal mortality review;
- Patient feedback;
- Staff feedback;
- Coroner's cases;
- Clinical guidelines; and
- Recent investigations / reviews / inquiries including those that are external to Belfast HSC Trust

Information is triangulated across multiple data sources to identify areas for improvement. Key learning is disseminated to staff groups. Identified safety priorities are then addressed through departmental quality improvement initiatives.

Recommendation 18**Priority 1**

18.1 Each HSC Trust should ensure appropriate partnership working with joint responsibility and accountability for governance within maternity services between midwifery and obstetrics at a senior level.

18.2 Each HSC Trust should ensure there is an appropriately constituted multidisciplinary governance group for 'learning and improvement' within maternity services that uses learning from a range of internal and, where relevant, external sources to identify key safety priorities that can be used to drive programmes of audit, quality improvement and staff education within maternity.

3.4.9 Learning from harm

Learning from harm is an essential component of ensuring patient safety within maternity services. It enables deficits in the systems for delivery of care to be identified so that improvements can be made to avoid harm occurring in future; where relevant, it allows for learning to be shared beyond specific service area where the incident occurred.

In Northern Ireland, a number of mechanisms exist by which incidents of harm are reviewed. These comprise the SAI review process, coroner's investigations and, specific to maternity, the Perinatal Mortality Review Tool (PMRT) process⁸².

In July 2022 RQIA published its Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland⁸³. It found that implementation of the current regional procedure does not consistently derive learning, involve patients and families, or support staff. It recommended the co-design of a new procedure underpinned by an evidence based framework in order to deliver measurable and sustainable improvements.

Unlike in England, there is no external body such as Health Safety Investigation Branch (HSIB) to review Serious Adverse Incidents⁸⁴. Whilst SPPG has oversight of the Terms of Reference, timescales and outputs of Level 2 and Level 3 SAI reviews (incidents of harm where there is a likelihood of system learning), it is not involved in conducting the review. The lack of involvement of an external body and difficulties in securing panel members with the appropriate expertise can pose challenges for the independence of SAI panels and the capacity of HSC Trusts to undertake SAI reviews.

During fieldwork, the ERT heard from clinical staff who had been the subject of SAI reviews and those who had been chairs and members of SAI panels. The ERT was informed that, although staff understood the purpose of the process was to identify

system learning, some staff experienced the process as stressful and intimidating. The ERT also heard of a lack of training, time and administrative support for SAI panel members and of a lack of availability of independent chairs to undertake SAI reviews, which had resulted in a backlog in some HSC Trusts. The resulting impact is that timescales for SAI reviews can be significantly protracted meaning that the SAI report may be issued many years after the event, missing an opportunity to disseminate learning and implement improvements sooner.

PMRT was introduced in Northern Ireland in 2022 and has been received positively by clinical staff working within HSC Trusts. It is national standardised tool which enables high-quality multidisciplinary reviews of stillbirth and neonatal deaths taking into account the need to involve and inform bereaved families. It is based on the principle of 'review once, review well' and provides an explanation of why the baby died and whether the death was preventable.

The ERT was informed that issues may arise when perinatal mortality cases also meet the threshold for a separate Serious Adverse Incident review. DoH issued correspondence, HSS (MD) 1/2023, to HSC Trusts in January 2023 stating that a multidisciplinary mortality review should be progressed in every stillbirth and neonatal death. The ERT has reviewed this correspondence and considers that it does not take account of cases, where, in addition to fetal or neonatal mortality, there is harm that meets the threshold for an SAI review. The ERT was informed during fieldwork that the undertaking of two processes can cause unnecessary duplication and add to the distress of parents and staff.

Furthermore, the ERT heard concerns that resource allocation to undertake PMRTs across HSC Trusts has not been proportionate to need, with all HSC Trusts receiving the same funding despite variation in number and complexity of cases. The ERT considers that PMRT funding should be proportionate and, as part of the design of a new regional procedure for SAI reviews, the SAI process for learning from cases where there has been a stillbirth or neonatal death should be aligned to the PMRT process. Such alignment would serve to ensure more timely learning and improvement, and ideally that HSC Trust review processes are concluded for bereaved parents in advance of any future pregnancy.

Recommendation 19

Priority 2

DoH / SPPG / PHA, in co-designing a new regional SAI procedure, should consider aligning the SAI process for reviewing cases, where there has been a stillbirth or neonatal death, to the PMRT process.

3.5 Safety Culture

Effective governance systems and processes require to be underpinned by a culture of safety. Safety culture within maternity services reflects the values, attitudes and behaviours of managers and clinicians in relation to the elements of culture that have a direct impact on clinical outcomes for women and babies. These cultural elements encompass psychological safety, just culture, and learning culture. They determine whether staff feel able to report incidents or raise concerns, whether they feel empowered take ownership of problems and assume responsibility for driving improvements; it also determines how they are treated and supported when care goes wrong. Safety culture within an organisation is strongly influenced by senior system leaders who are in a privileged position to demonstrate values, model positive behaviours and ensure that HSC Trust systems support quality and safety.

As part of this review, the safety culture of HSC maternity services was assessed through three key methodologies: Maternity Safety Culture Staff Survey; semi-structured focus groups with management staff and staff in clinical leadership roles; and focus groups with front-line staff during site visits to each HSC Trust.

The response rate to the Maternity Safety Culture Staff Survey varied according to HSC Trust. Overall, 35.26% of maternity staff completed the survey; the ERT had aimed for at least 60%. As this ranged from 17.59% in the HSC Trust with the lowest uptake to 54.4% in the highest, caution must be applied when drawing conclusions at an individual HSC Trust level. Nonetheless, the ERT consider that the responses are useful in gaining an insight into the views and experiences of HSC maternity staff members and, when triangulated with information from staff focus groups, can be utilised to inform recommendations which are made at a regional level.

3.5.1 Psychological Safety

Psychological safety is a core component of safety culture. Defined as a “shared belief held by members of a team that the team is safe for interpersonal risk taking”, it is about staff feeling enabled and confident to contribute ideas or suggestions, to ask questions and to respectfully challenge each other⁸⁵. It is about safe and supportive environments that give people permission and space to speak freely without the fear that they will be humiliated or punished as a result. Psychological safety is the antithesis of a hierarchical mind-set and ensures that all members of the team are valued and respected regardless of role or grade. It is particularly crucial in enabling staff to raise concerns about patient safety.

A consistent theme across all HSC Trusts was that despite challenging circumstances, clinical teams work well together. The ERT was complimentary of the dedication and comradery of the maternity teams they met with and given this evident collegiality was not surprised to hear examples of psychological safety. In a number of HSC Trusts,

staff reported that in multidisciplinary settings, all staff, regardless of their role or level of seniority, felt comfortable asking questions or contributing to the discussion. Other HSC Trusts reported good psychological safety within their own specialty teams, especially when working with staff at the same grade or level. However, this was less evident for MDT teams; midwives across some HSC Trusts reported that it can feel difficult to challenge medical staff.

During site visits, the ERT met with medical and midwifery staff who reported that respectful challenge was more difficult for junior members of the team, especially when challenging a senior staff member. This was corroborated by survey findings. Just 34.2% of respondents said they would speak up to question “the decisions or actions of those with more authority”; ranging from 28.6% to 40.9% across HSC Trusts. The ERT considered that the proportion of staff who felt that they were not able to speak up was substantial and that more should be done by HSC Trusts to encourage respectful challenge within and across teams.

In the absence of psychological safety at team level, HSC Trusts must rely on effective mechanisms for escalating and raising concerns. A number of HSC Trusts reported using leadership walk-arounds, listening rooms, and informal ‘open door’ policies to reduce barriers to raising concerns. One HSC Trust had provided mandatory ‘openness’ training to staff and had in place a non-executive director acting as a whistleblowing champion. The ERT considered this to represent good practice. However, despite HSC Trust efforts, there remains a clear reluctance amongst staff to raise concerns. In response to the survey question, “Staff will freely speak up if they see something that may negatively affect patient care” just 60.8% of respondents agreed. This ranged from 49.6% to 70.2% across HSC Trusts.

During focus groups with clinical staff, the ERT heard how staff know who to approach and the mechanism by which they could raise concerns within their respective HSC Trusts. However, the experience of doing so was reported to be variable. Whilst some staff reported feeling confident and supported to escalate concerns, few staff were able to cite examples of where this had led to tangible improvements. Furthermore, the perception of a blame culture was identified as a persistent barrier to raising concerns. 48.6% of respondents stated that they were afraid to raise concerns in case it impacted negatively upon them. In one HSC Trust, the ERT heard how a staff member felt ostracised by colleagues after they raised concerns using the HSC Trust’s whistleblowing policy. The ERT was saddened to hear this and considers that more should be done to support staff, who in the interest of women and babies, follow their professional code of conduct and raise concerns about patient safety.

3.5.2 Learning Culture

Healthcare organisations with a strong learning culture seek out learning and use it to embed improvements. A holistic approach to learning encompasses not just learning from harm but also from excellence.

Although learning from incidents is enabled by functional systems for incident reporting, a culture supportive of reporting is also required. Reporting behaviours require an understanding of the importance and benefits, alongside a confidence in staff that if they report concerns they will not suffer adverse consequences; in many respects, this is closely linked to psychological safety.

During fieldwork, the ERT found that whilst Datix incident reporting was used in all HSC Trusts, this was largely used as a reactive mechanism to report incidents that had caused harm and was less commonly used to report 'near misses' or to evidence and address risk. This was supported by the findings of the staff survey which showed that in response to the question, "When a mistake is made that could harm the patient, but does not, how often is this reported?", 74.3% answered 'always' or 'almost always'.

Some HSC Trusts were more proactive in their approach, encouraging staff to report incidents and had implemented systems for oversight, theme and trend analysis in order to inform staff education and quality improvements. Despite these proactive approaches, staff reticence in reporting was still identified by analysis of survey responses. This is likely linked to fear of negative repercussions. 48.8% of respondents stated that they would be "fearful that they may be blamed for incidents of mistakes that they report"; 46.6% stated that they "worry that mistakes they make are recorded in their personnel file". The ERT considers that more should be done to allay anxieties and reassure staff that incident reporting will not impact negatively upon them.

One barrier to incident reporting is a limited belief in its benefits. Only 56.6% of respondents to the staff survey stated that they believed mistakes had led to positive changes; a factor likely not helped by a lack of feedback regarding incidents staff report with only 42.7% of staff stating that they received feedback on incidents reported. During fieldwork, the ERT heard from clinicians across HSC Trusts who stated that they had not received feedback on incidents they submitted through the Datix system. In some HSC Trusts, we heard that feedback is dependent on the type of incident and also whether staff had opted in for feedback by providing their email address. One HSC Trust had a folder system whereby staff could chase up the outcome of Datix submissions.

Nonetheless, whilst it is difficult for HSC Trusts to provide feedback on all individual Datix submissions, the ERT considers that more should be done to demonstrate to staff how incident reports feed into systems for learning and improvement.

Dissemination of trend and theme analysis via ‘learning and improvement’ groups is one useful mechanism that should be considered.

Learning from excellence is a less well established concept within HSC. It recognises that despite system complexity, human factors and a large number of variables, most of the time care is satisfactory and outcomes are good⁸⁶. The benefits go beyond improving staff morale through recognition; there is value in understanding and replicating the key ingredients to success in order to improve consistency and reliability of systems for safe delivery of care. This is all the more important when one considers the limitations of learning from harm, where despite significant focus on this area, the resulting efforts to enhance systems often foster rigidity without achieving the expected improvements in patient safety.

Two HSC Trusts had introduced systems for learning from excellence. These HSC Trusts had also introduced the GREAT-ix initiative^{xvi} whereby staff can formally thank colleagues and help them feel valued and respected. During focus groups, staff told us how much they appreciated and benefited from the positive feedback they had received.

3.5.3 Just Culture

The 2022 RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents found that staff do not always feel supported by the SAI process and recommended that a new regional SAI procedure is designed which is underpinned by just culture principles. A just culture recognises that when adverse incidents occur, they do so within the context of complex and imperfect systems⁸⁷. Errors are rarely intentional or solely due to the actions of individuals. Therefore, apportioning blame when incidents occur is not only unjust and detrimental to staff, it is ineffective at driving improvement, does not prevent harm and hinders essential learning⁸⁸. Learning is dependent on a level of openness that occurs when just culture is embedded within organisations.

Perhaps as an outworking of the recent RQIA review, a number of HSC Trusts reported that they were implementing a just culture approach to deriving learning from Serious Adverse Incidents. Furthermore, the majority (63%) of survey respondents agreed that, “When adverse incidents are reviewed it is to improve systems and make services safer for patients, as opposed to blaming the individuals involved”.

^{xvi} GREAT-ix is an initiative to allow NHS staff to say thank you to each other and help make their colleagues feel valued and appreciated. Submitting a GREAT-ix aims to capture the positive events in the NHS and improve safety by sharing and spreading excellence.

Nonetheless, the ERT considers that a proportion of staff still perceive there is a blame culture within HSC maternity services.

The perception of blame was explored with staff during fieldwork. One HSC Trust had identified concerns regarding a blame culture through its staff surveys and had already commenced work to implement a just culture; this is to be commended. However, despite these efforts, the ERT heard from clinicians within the HSC Trust who reported that there was still a residual blame culture, they were afraid of making mistakes and had no faith in the SAI process which was described as 'not fit for purpose'.

Across some HSC Trusts, clinicians reported that they found, not just SAI reviews intimidating, but also HSC Trust mechanisms for initial incident review. Some reported that they had been asked to write statements in response to low level incidents and had not been provided with the support to do so. Some clinicians stated that a meeting to talk through the case and ascertain if support was required would have been preferable.

Just culture has benefits that go beyond learning and improvement. When just culture is augmented by a restorative approach, organisations can better identify and address the needs of those impacted by healthcare-related harm⁸⁹. This includes the needs of staff who are adversely impacted by vicarious trauma. During fieldwork, the ERT examined the support available for staff in the aftermath of an incident. Most HSC Trusts reported debrief sessions such as 'hot debriefs' or 'diffuse and debrief' sessions to provide space for staff to discuss serious adverse incidents following their occurrence. Some HSC Trusts described support through occupational health and HSC Trust psychology services. Despite these efforts only 41.7% of survey respondents agreed that there were good support mechanisms in place following an incident.

Coronial investigations and the associated media coverage were reported as being particularly traumatic by the small number of staff who had undergone this experience. The ERT heard from clinicians in a number of HSC Trusts who felt that HSC Trust processes did not adequately support staff impacted by coroner investigations. One HSC Trust has implemented a specific programme designed to support staff involved in SAIs and coroners' cases; this was considered by the ERT to represent good practice. Given the psychological impact on staff who seek to remain well in order to provide safe care to women and babies, the ERT considers that all HSC Trusts should provide support to staff impacted by SAIs or coronial investigations.

Recommendation 20**Priority 2**

20.1 Each HSC Trust should undertake work to ensure that the principles of fairness, openness and learning are embedded within HSC Trust systems and processes for raising concerns, incident reporting and incident review.

20.2 All HSC Trusts should ensure that they have mechanisms in place to support staff impacted by serious adverse incidents or coronial investigations.

3.6 Maternity services and interfaces**3.6.1 Maternity services**

Healthcare services should be designed and configured to ensure safe sustainable care that meets the needs of the population. Within Northern Ireland, there are eight obstetric units and six alongside midwifery led units; all five HSC Trusts provide a home birth^{xvii} service. NICE guidance recommends that services are configured so that women can choose to give birth in four different settings: obstetric unit, stand-alone midwife-led birthing unit, alongside midwife-led birthing unit and home birth. Following the closure of the Downe Hospital and Lagan Valley MLUs to births, there are no stand-alone midwifery- led birthing units in Northern Ireland. This limits the midwifery led birthing options available to women and means some women are now travelling greater distances to their birthing location; a factor which is likely to drive an increase in the number of women opting to give birth at home.

Due to significant challenges with service sustainability, the Northern HSC Trust opened a public consultation on 25 November 2022, 'Working with you to Transform Acute Maternity Services', to consult on two options to reconfigure maternity services in Northern HSC Trust; one option is closure of Causeway maternity unit to all births and the other is conversion to a stand-alone midwifery led unit⁹⁰. On 23 March 2023, the Northern HSC Trust Board approved the recommendation that all hospital births should take place at Antrim Hospital. Implementation of this recommendation will lead to women travelling greater distances to give birth.

Furthermore, temporary withdrawal of surgical services on the SWAH site in the Western HSC Trust has led to concerns that this may impact on the sustainability of its maternity services. Currently, Western HSC Trust has criteria in place whereby some women with higher risk pregnancies are advised to birth in Altnagelvin, instead

^{xvii} Note: The home birth service in Western HSC Trust was suspended temporarily due to staffing pressures and resumed in November 2022.

of the SWAH; for some women this may require a journey time of up to two hours, presenting obvious challenges.

Whilst decisions must be made to ensure safety and sustainability, the configuration of maternity services and its impact on service user experience and outcomes should be carefully considered as part of any future strategy for maternity care in Northern Ireland.

3.6.2 Interface with neonatology services

Place of birth can sometimes be determined by factors outside the control of women or clinicians. One such factor is the location and availability of neonatal cots. When it is deemed that preterm birth is likely, arrangements should be made for women to give birth in a location where a neonatal cot at the appropriate level is available⁹¹. Not infrequently, this can require the woman to be transferred to another unit prior to the birth of the baby.

Unlike in other parts of the UK, in utero transfers are not managed centrally and it is clinicians, often junior obstetric staff, who must phone other units to find a cot and maternal bed; and seek permission from receiving neonatal and obstetric teams for patient transfer. Whilst supported by standardised regional documentation and NIAS arrangements for transfer, the process can be time consuming, impacting not just on staff but also on patient experience and outcomes. The ERT considers that the introduction of a regional service to locate cots and co-ordinate in utero and neonatal transfers would improve efficiency and reduce delays.

The ERT heard concerns from neonatologists that the regional distribution of cots and accompanying resource at present does not meet the needs of the population. National benchmarking has demonstrated markedly poorer neonatal outcomes in Northern Ireland⁹². At the time of fieldwork, work was underway to address these at a clinical level. However, it was being undertaken solely by clinicians working within neonatology rather than as a joint approach with obstetrics. Since maternity care is an important factor impacting on neonatal outcomes, this siloed approach represents a missed opportunity to drive improvements through partnership working. It is in this arena that collaboration between the Neonatal Network and a newly established Maternity Network would be most beneficial.

Furthermore, the ERT heard that there are limits to what can be achieved through clinician-led improvements within the constraints of existing resources. The ERT considers that it will be difficult to achieve parity with other parts of the UK without an external review of how neonatal services are commissioned, resourced and configured in Northern Ireland. The ERT notes that the Neonatal Network in Northern Ireland differs from Neonatal Networks in other parts of the UK. There is no regional specification for Neonatal Services and mechanisms for accountability require to be

strengthened; without these there will be ongoing challenges for assuring and improving quality and safety.

Recommendation 21	Priority 2
<p data-bbox="204 394 1390 539">21.1 DoH should commission an external regional review of quality and safety of neonatal services in Northern Ireland. This review should explore the planning, commissioning and delivery of services in addition to the governance arrangements that support safety.</p> <p data-bbox="204 577 1390 651">21.2 DoH / SPPG should consider introducing a regional service to locate cots and co-ordinate in utero and neonatal transfers.</p>	

3.6.3 Interface with community services

The current provision of antenatal care takes place either in a hospital setting or within the community. When women avail of community-based antenatal care, this is largely delivered by community midwives who are situated within GP practices but are employees of HSC Trust maternity services.

RQIA engagement with GP representatives indicated that there is regional variation in the provision of antenatal care, with a minority of GPs performing antenatal checks and the majority of GPs less skilled and less experienced in antenatal care than previously, when GPs would have participated in shared care arrangements. It was reported that GPs more commonly have contact with women in the postnatal period.

We heard that a lack of standardisation in maternity care pathways across HSC Trusts can pose difficulties for GPs who do not have access to relevant information on how HSC Trust pathways and services differ; this can be a challenge when patients and GP practices cross HSC Trust boundaries.

We also heard challenges in the ownership of performing, following up and acting upon investigations. We heard examples of GPs being asked to perform or chase results without the provision of specialist advice or support in acting on them. The ERT considers this to be inappropriate as it carries intrinsic risk, is likely to be an inefficient use of GP resource, and places GPs in unnecessarily difficult situations where they are practising outside their area of expertise.

We explored this issue with HSC Trusts. Most HSC Trusts reported that GPs are not asked to perform investigations for maternity patients. One HSC Trust informed us that this only happens in exceptional circumstances where the patient is not able to attend the maternity service; it was stated that the requesting individual has ownership irrespective of who performs the test. We were informed that a regional primary and

secondary care interface group has been established to address these issues and that communication between primary care and maternity services has improved as a result.

GP representatives also relayed concerns in relation to prescribing. Hospital medical staff in Northern Ireland cannot issue prescriptions to community pharmacists; for this reason, GPs are frequently asked to prescribe treatment for Urinary Tract Infections in pregnancy. This adds to GP workload pressures and can create delays in women receiving antibiotics as it takes time for lab results to be chased and treatment advice notes to be sent to and received by GP practices. We heard that in two HSC Trusts obstetricians issue prescriptions to the hospital pharmacy as an interim solution and that the regional working group is working to address prescribing issues across all HSC Trusts. The ERT considers that HSC Trusts should invest in upskilling community midwives to prescribe medication, which would serve to ensure timely treatment is provided by maternity teams working within a community setting.

Despite improvements in technology, communication with GPs remains an issue in Northern Ireland. GP systems do not automatically link with HSC Trusts and there are governance issues with the use of GP email addresses to send information. All HSC Trusts operate self-referral mechanisms for antenatal booking; however, we heard from GP representatives that GPs are not always aware that a woman has booked for antenatal care. Therefore, unless the woman tells the GP she is pregnant then the GP may not know this when providing advice or making decisions around care and treatment. HSC Trusts informed us that GPs are sent a notification by way of a letter in the post to inform them when a patient has booked for maternity care, and that this occurs following the initial booking visit.

Any form of postal notification can take time, which is of concern in circumstances where urgent or important information requires to be relayed. We heard from GP representatives that although all HSC Trusts notify GPs when there is a poor outcome such as miscarriage or stillbirth, there can be delays in GPs receiving information which runs the risk of the patient receiving inadvertently insensitive communication in the intervening period.

The ERT was informed that issues with communication from HSC Trusts can impact on other community health professionals. We heard one example of a health visitor attending the home of a bereaved parent to congratulate them on the birth of the baby, having not been informed that the baby sadly passed away in the neonatal period. The ERT considers that HSC Trusts should ensure their systems for communicating with community midwives, GPs and health visitors facilitate timely notification of poor outcomes.

- 22.1 Each HSC Trust should ensure that the interface between maternity services and primary care maximises safety for women and babies. This should include robust arrangements for communication with all relevant professionals (community midwives, GPs, health visitors); appropriate maternity service ownership of the undertaking of investigations; and monitoring and prescribing arrangements in the antenatal and postnatal period.
- 22.2 SPPG / PHA and HSC Trusts should work together to review the capacity and capability of Community Midwifery Teams to meet the needs of the local population. Consideration should be given to advancing midwifery practice with particular focus on the introduction of midwifery prescribers.

3.6.4 Interface with Emergency Departments

Managing the interface with Emergency Departments (ED) is especially important in the current climate where EDs are under considerable pressure. Women who attend ED may face longer waits for triage and assessment than women who attend maternity assessment units, and may be seen by a clinician with less skill and experience in managing pregnancy-related problems, resulting in further delays as referral and transfer to maternity is required. Therefore, it is important from the outset that women are directed appropriately to the correct service to meet their needs.

HSC Trusts informed us that women with obstetric complaints are advised to attend maternity assessment units. Where there is an acute non-obstetric problem such as trauma, assault and overdose, women are directed to ED in the first instance with review from obstetrics as required. Women may also attend ED with suspected miscarriage or ectopic pregnancy and the arrangement across HSC Trusts is that, depending on gestation and clinical condition, these women are either referred to Early Pregnancy Units or Maternity Assessment Units; those who are clinically unstable are assessed by maternity and gynaecology teams within the Emergency Department. There was variation across HSC Trusts in the opening hours and gestational limits set by Early Pregnancy Units.

ED environments, particularly in the current context where there is frequent overcrowding, are not conducive to caring for women with pregnancy loss. Furthermore, ED staff are less accustomed to managing women with miscarriage, ectopic pregnancy and stillbirth. Therefore, it is all the more important that there are robust arrangements in place to support ED staff to provide care to women who present with these problems. Some HSC Trusts reported that they provide training on pregnancy care pathways and managing pregnancy problems to ED staff during induction; the Royal College of Emergency Medicine also offers a training module on pregnancy-related presentations. Some HSC Trusts described arrangements whereby

bereavement midwives provide in-house training and resources on pregnancy loss to ED staff. The ERT considers this to represent an example of good practice that should be provided across all HSC Trusts.

Recommendation 23

Priority 2

23.1 Each HSC Trust should include within ED staff induction programmes, information on early pregnancy / maternity care pathways and training in managing ED presentations during pregnancy.

23.2 Each HSC Trust should provide training and guidance to ED staff on how to provide sensitive and compassionate care to women presenting with suspected or confirmed pregnancy loss.

Section 4: Conclusion and Summary of Recommendations

This RQIA review is the first review of its kind to examine governance arrangements and safety culture within HSC maternity services. Undertaken at a time of national learning arising from failings with NHS maternity services, it highlights how increasing complexity compounded by significant staffing shortages pose considerable challenges for service delivery.

The Expert Review Team acknowledges and commends the dedication of midwives and medical staff to the provision of safe, effective and compassionate care to women and babies. However, they recognised that there is an overreliance on the good will of these dedicated staff members, and burn out, exhaustion and work-related stress were all too evident. Despite these challenges it is evident that clinicians remain committed to delivering safe care and the Expert Review Team was heartened to see examples of good practice and strong teamwork across HSC Trusts. Nonetheless, more must be done to support staff to do their job well.

Staffing is an essential building block of safe maternity care and workload and workforce planning should take account of increasing social complexity, as well as the need for managerial, administrative and ancillary staff. Arrangements for securing additional cover at short notice should consider the impact on staff wellbeing. On the whole, stability and resilience within the maternity workforce needs to be maximised to reduce the need to resort to escalation measures, lessen reliance on locum and agency staff and to ensure there are safe staffing levels 24/7.

As part of this work to enhance stability within the maternity workforce, more needs to be done to attract and retain talented staff members. HSC Trusts should invest in mentorship programmes and support for staff wellbeing, along with training for clinicians and managers on psychological safety, civility and human factors. When care goes wrong, staff should be adequately supported by systems and processes that embody the principles of fairness, openness and learning. These are vital to ensure a just and learning culture within HSC.

There is a public perception that patient expectations are at an all-time high. However, the women and advocacy groups we engaged with have made it clear that what women want is for the basics to be done well. Women value respectful relationships with healthcare professionals, where they are treated as partners in decision making processes and provided with unbiased information and choice on a range of birthing options.

The healthcare system must do more to recognise and respond to the needs of women and babies. A new maternity strategy is required to provide a strategic direction for maternity care in the changed context of increased complexity, national learning and

ongoing challenges with service delivery. The Maternity Collaborative was highlighted as an example of good practice. However, a formal Maternity Network requires to be established in order to drive improvement across HSC maternity services in line with regional safety priorities. Work must be jointly led by relevant stakeholders to agree the metrics required to monitor quality and safety within HSC maternity services; these should be meaningful and sensitive enough to alert the HSC system to safety concerns so they can be addressed at an early stage.

HSC Trust Boards play a critical role in assuring and improving safety within HSC maternity services. Each HSC Trust Board should nominate a safety champion to ensure the need to achieve safe outcomes for women and babies does not get lost amongst the immediate pressures of waiting lists and unscheduled care pressures that all HSC Trusts face. HSC Trusts should ensure that senior leaders within midwifery and obstetrics adopt a partnership approach to governance and are facilitated to have direct and regular engagement with the Trust Board.

Governance within maternity services should go beyond examining incidents or Datix reports. A holistic approach to assurance looks at a range of information, including service user and staff feedback, and is supported by a multidisciplinary perspective to identify safety priorities to inform staff education and quality improvement programmes.

Decision making on place of birth should be underpinned by evidence based practice and robust arrangements for supporting women who seek care outside guidance. Maternity pathways for scheduled and unscheduled care need to be strengthened to reduce delays for women undergoing elective and emergency births. Furthermore, postnatal pathways for women with social complexity must be improved to maximise outcomes for vulnerable women and babies. The Expert Review Team recommends that policy makers and commissioners consider all of these as part of any new strategy for Northern Ireland maternity care.

In total, the review makes 23 recommendations for improvement. The learning identified is applicable to all HSC Trusts. Whilst HSC Trusts may be at differing stages of a maternity improvement journey, all HSC Trusts will benefit from work to strengthen their systems and approach to governance and safety culture.

It is acknowledged that there are considerable financial constraints in the current climate. It is intended that the implementation of these recommendations will lead to cost-effective improvements whilst seeking to maximise patient safety.

Furthermore, the Expert Review Team recognises that HSC Trusts cannot and should not do this alone; they must be supported by HSC system partners, policy makers, commissioners and regulators to ensure a whole system approach to improving and assuring safe maternity care for women and babies in Northern Ireland.

Summary of Recommendations

The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report.

Priority 1 - completed within 6 months of publication of report

Priority 2 - completed within 12 months of publication of report

Priority 3 - completed within 18 months of publication of report

Recommendation 1

Priority 2

- 1.1 Each HSC Trust should develop a vision for safety within maternity HSC services that is supported by a strategic plan and is clearly understood by all relevant stakeholders. This should be co-produced with involvement from the Trust Board, senior management team, service users and their families, and all maternity staff groups.
- 1.2 DoH / SPPG should work with all HSC Trusts, PHA, RQIA, Royal Colleges (RCOG, RCM, RCGP) and service user representatives to develop a new maternity strategy for Northern Ireland which includes a clear focus on safety.

Recommendation 2

Priority 3

- 2.1 Each HSC Trust should develop a Quality Management System that utilises relevant data on both activity and outcomes to facilitate oversight, assurance and improvement of safety within maternity services.
- 2.2 DoH / SPPG, PHA, HSC Trusts should work in collaboration with RQIA, GMC / NMC and the Maternity Collaborative to develop regionally agreed metrics for monitoring quality and safety within HSC maternity services. These should be made available through the development of a central repository of data that is accessible to all relevant stakeholders.

Recommendation 3

Priority 2

- 3.1 DoH should endorse and fund the Maternity Collaborative as a Maternity Network with a recognised role in improving safety within maternity services across the region. The Maternity Network should be underpinned by strong governance arrangements and clear lines of accountability.
- 3.2 The Maternity Network should be supported by DoH / SPPG / PHA to lead a QI programme of work that is aligned to clearly defined regional priorities for improving safety within maternity. Where beneficial, the Maternity Network and Neonatal Network should work together to improve neonatal outcomes.

- 3.3 Each HSC Trust should establish multidisciplinary QI teams for maternity to support the work of the Maternity Network and to lead a Trust-specific QI programme of work within maternity.

Recommendation 4

Priority 1

- 4.1 Each HSC Trust Board should nominate a non-executive member to act as a safety champion for maternity services.
- 4.2 The Head of Midwifery and Clinical Director for Maternity in each HSC Trust should be facilitated to liaise directly with the Trust Board on a regular basis; these arrangements should ensure that midwifery and obstetrics are given an equal voice.
- 4.3 Each HSC Trust should have effective mechanisms in place to ensure HSC Trust Boards and senior leaders are visible and accessible to clinical teams.

Recommendation 5

Priority 2

- 5.1 DoH / SPPG and HSC Trusts should work together to define the minimum skills, competencies and training requirements for specific HSC Trust management roles in relation to maternity services.
- 5.2 DoH / SPPG and HSC Trusts should consider working with the HSC Leadership Centre to design and implement a regional training programme for medical leaders working within HSC at Clinical Director level and above.

Recommendation 6

Priority 2

- 6.1 SPPG, PHA and HSC Trusts should augment the Birthrate Plus analysis with an assessment of the additionality required to meet the needs of the population with social complexity. In lieu of formal methodology to determine such additionality, commissioners and providers should exercise their professional judgement; the use of a Professional Judgement Tool should be considered.
- 6.2 SPPG, PHA and HSC Trusts should ensure that workforce planning for maternity services takes account of the need for managerial, administrative and ancillary staff, in addition to clinical staff.

Recommendation 7

Priority 1

- 7.1 DoH / SPPG should consider liaising with RCOG to extend the 'Safe Staffing in Maternity Tool' to include HSC Trusts in Northern Ireland.

- 7.2 SPPG and HSC Trusts should work together to review the capacity and capability of obstetric and anaesthetic teams to safely deliver maternity care out of hours.
- 7.3 Commissioners and HSC Trusts should ensure that there is adequate on site 24/7 anaesthetic cover to enable immediate attendance of anaesthetists to emergencies on delivery suite.

Recommendation 8

Priority 2

- 8.1 DoH / SPPG and HSC Trusts should work together to determine the minimum allocation of programmed activities (PAs) for specific leadership and governance roles within consultant obstetrician job plans.
- 8.2 Each HSC Trust should ensure there is appropriate time available, provided as funded programmed activities (PAs), to facilitate the undertaking of leadership and governance responsibilities, appropriate to their local Trust context. Sufficient administrative support should also be provided.
- 8.3 Where required, HSC Trusts should work with commissioners to expand the number to consultants to enable the required delivery of both clinical and non-clinical work to support safety within maternity services.

Recommendation 9

Priority 2

- 9.1 Each HSC Trust should ensure that arrangements for job planning and appraisal are in line with contractual obligations and produce outputs that enable consultants to fulfil their roles and responsibilities and ensure maternity services meet the needs of the population.
- 9.2 HSC Trusts should consider the introduction of an electronic platform for job planning to enable appropriate allocation and distribution of clinical and non-clinical work across consultant teams.

Recommendation 10

Priority 1

DoH / SPPG should undertake an evaluation of non-recurrent spending on agency and locum staff within HSC maternity services and should consider converting non-recurrent to recurrent funding to increase the number of substantive posts to enhance capacity, stability and resilience within HSC maternity services.

Recommendation 11

Priority 1

Each HSC Trust should review their arrangements for staffing escalation and should ensure that the measures used to roster additional staff at short notice are sensitive to their wellbeing needs. In particular, HSC Trusts should engage with staff to explore suitable alternatives to 'SOS' WhatsApp groups.

Recommendation 12**Priority 2**

- 12.1 All HSC Trusts should ensure that clinical and management-level staff within maternity services receive training on human factors, psychological safety and civility.
- 12.2 Each HSC Trust should implement proactive approaches to supporting staff wellbeing for all maternity staff groups. This should include: adequate induction, mentorship programmes and mechanisms, such as Schwartz rounds and other forms of peer support, to support staff with emotionally challenging aspects of their work; augmented with access to counselling, as required.

Recommendation 13**Priority 2**

- 13.1 All HSC Trusts should ensure that there are robust arrangements for the delivery of training for maternity staff, which includes protected time for multidisciplinary attendance, and adequate space and equipment.
- 13.2 DoH / SPPG, HSC Trusts, Royal Colleges (RCOG, RCM) and the Maternity Collaborative should work together to determine the minimum training requirements for staff working within HSC maternity services. Mandatory training completion rates for maternity staff groups should be collated as a performance metric and monitored by the Trust Board and commissioners.

Recommendation 14**Priority 2**

- 14.1 Each HSC Trust should ensure there are robust arrangements for developing, reviewing and updating local guidelines, policies and protocols. HSC Trusts should ensure an appropriate level of multidisciplinary involvement and oversight by local maternity governance groups.
- 14.2 DoH / SPPG should work with PHA, all HSC Trusts, RCM, RCOG and service users to ensure there is clear up-to-date guidance on the regional arrangements for admission to midwifery led units and choosing to birth at home.

Recommendation 15**Priority 1**

- 15.1 Each HSC Trust should ensure there are robust arrangements for counselling and providing care to women who seek 'care outside guidance'. Arrangements should utilise a partnership approach that respects women's autonomy whilst supporting decision making that is fully informed ensuring women are provided with all relevant information on risk, including information on ambulance transfer times.
- 15.2 Each HSC Trust should ensure that there is sufficient support and guidance for midwives and obstetricians who are required to support women who choose 'care outside guidance'.

Recommendation 16**Priority 3**

- 16.1 Each HSC Trust should ensure that there are person-centred maternity pathways for women with social complexity. Each HSC Trust should provide training to maternity staff on how to reduce inequalities and provide support to ethnically diverse women and women with vulnerability factors.
- 16.2 DoH / SPPG / PHA and HSC Trusts should work together to enhance and extend the provision of postnatal support provided to women and babies with social complexity. This should include co-ordinated multi-agency input from a range of HSC and third sector organisations; such as community midwifery teams, social services, health visitor services, perinatal mental health services, Family Nurse Partnership and Sure Start.

Recommendation 17**Priority 1**

- 17.1 Each HSC Trust should undertake work to improve pathways of scheduled and unscheduled maternity care to ensure safety; where this is not feasible within existing budgets, this should be escalated to commissioners.
- 17.2 Each HSC Trust should ensure that staffing allocation, clinical pathways, systems for prioritisation and patient flow are optimised to maximise outcomes and reduce delays, specifically for women undergoing induction of labour and planned caesarean births.

Recommendation 18**Priority 1**

- 18.1 Each HSC Trust should ensure appropriate partnership working with joint responsibility and accountability for governance within maternity services between midwifery and obstetrics at a senior level.
- 18.2 Each HSC Trust should ensure there is an appropriately constituted multidisciplinary governance group for 'learning and improvement' within maternity services that uses learning from a range of internal and, where relevant, external sources to identify key safety priorities that can be used to drive programmes of audit, quality improvement and staff education within maternity.

Recommendation 19**Priority 2**

DoH / SPPG / PHA, in co-designing a new regional SAI procedure, should consider aligning the SAI process for reviewing cases, where there has been a stillbirth or neonatal death, to the PMRT process.

Recommendation 20**Priority 2**

- 20.1 Each HSC Trust should undertake work to ensure that the principles of fairness, openness and learning are embedded within HSC Trust systems and processes for raising concerns, incident reporting and incident review.
- 20.2 All HSC Trusts should ensure that they have mechanisms in place to support staff impacted by serious adverse incidents or coronial investigations.

Recommendation 21**Priority 2**

- 21.1 DoH should commission an external regional review of quality and safety of neonatal services in Northern Ireland. This review should explore the planning, commissioning and delivery of services in addition to the governance arrangements that support safety.
- 21.2 DoH / SPPG should consider introducing a regional service to locate cots and co-ordinate in utero and neonatal transfers.

Recommendation 22**Priority 2**

- 22.1 Each HSC Trust should ensure that the interface between maternity services and primary care maximises safety for women and babies. This should include robust arrangements for communication with all relevant professionals (community midwives, GPs, health visitors); appropriate maternity service ownership of the undertaking of investigations; and monitoring and prescribing arrangements in the antenatal and postnatal period.
- 22.2 SPPG / PHA and HSC Trusts should work together to review the capacity and capability of Community Midwifery Teams to meet the needs of the local population. Consideration should be given to advancing midwifery practice with particular focus on the introduction of midwifery prescribers.

Recommendation 23**Priority 2**

- 23.1 Each HSC Trust should include within ED staff induction programmes, information on early pregnancy / maternity care pathways and training in managing ED presentations during pregnancy.
- 23.2 Each HSC Trust should provide training and guidance to ED staff on how to provide sensitive and compassionate care to women presenting with suspected or confirmed pregnancy loss.

Appendix A: Frameworks, standards and recommendations used to inform the development of the Assurance Framework

Organisation	Document
A Strategy for Maternity Care in Northern Ireland 2012-2018	A Strategy for Maternity Care in Northern Ireland 2012-2018. A maternity strategy for Northern Ireland 2012-2018 Department of Health (health-ni.gov.uk)
Care Quality Commission	CQC Maternity Framework, 2018. https://www.cqc.org.uk/sites/default/files/20200324%20900468%20NHS%20IH%20Maternity%20Core%20service%20v7.pdf
Department of Health	The Quality Standards for Health and Social Care, 2006. Quality Standards for Health and Social Care (health-ni.gov.uk)
Health Improvement Scotland	Pregnancy and Newborn Screening: General Standards, 2019. https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/pregnancy_screening_standards.aspx
National Institute for Health and Care Guidance	<p>NG 4: Safe midwifery staffing for maternity settings, 2015. Overview Safe midwifery staffing for maternity settings Guidance NICE</p> <p>CG 192: Antenatal and postnatal mental health: clinical management and service guidance, 2020. Overview Antenatal and postnatal mental health: clinical management and service guidance Guidance NICE</p> <p>QS 105: Intrapartum care, 2017. Overview Intrapartum care Quality standards NICE</p> <p>QS 192: Intrapartum care: existing medical conditions and obstetric complications, 2020.</p>

	<p>Overview Intrapartum care: existing medical conditions and obstetric complications Quality standards NICE</p> <p>QS 22: Antenatal Care, 2023. Overview Antenatal care Quality standards NICE</p> <p>NG 126: Ectopic pregnancy and miscarriage: diagnosis and initial management, 2021. Overview Ectopic pregnancy and miscarriage: diagnosis and initial management Guidance NICE</p>
National Patient Safety Agency	<p>Manchester Patient Safety Framework. https://documents.manchester.ac.uk/display.aspx?DocID=55125</p>
Northern Ireland Audit Office.	<p>Raising Concerns. A Good Practice Guide for the Northern Ireland Public Sector. Raising Concerns: A Good Practice Guide for the Northern Ireland Public Sector Northern Ireland Audit Office (niauditoffice.gov.uk)</p>
Ockenden Inquiry	<p>Independent Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust 2022. https://www.gov.uk/government/publications/final-report-of-the-ockenden-review</p>
Regulation and Quality Improvement Authority	<p>Review of the Maternity Strategy Northern Ireland, 2017. https://www.rqia.org.uk/RQIA/files/3d/3d4d9d13-8079-403f-80d6-ee79008718da.pdf</p> <p>Review of Perinatal Health Services in Northern Ireland, 2017. https://www.rqia.org.uk/RQIA/files/28/28f4ee85-a5e9-4004-b922-525bc41ae56d.pdf</p> <p>Review of the operation of HSC Whistleblowing Arrangements, 2016 https://www.rqia.org.uk/RQIA/files/71/714c4651-e428-4f85-8142-4f88e81ba0ac.pdf</p>

Royal College of Obstetricians and Gynaecologists	RCOG Standards for Maternity Care, 2016. https://rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/standards-for-maternity-care/
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Appendix B: References

- ¹ NISRA Birth Statistics. Available at: <https://www.nisra.gov.uk/publications/birth-statistics> Cited February 2023
- ² Health Committee. Fourth report - Safety of Maternity Services in England. Available at: <https://committees.parliament.uk/work/472/safety-of-maternity-services-in-england/> Cited February 2023
- ³ Information Analysis Directorate. Clinical / Social Negligence cases in Northern Ireland. DoH. December 2022. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/cscnc-ni-21-22.pdf> Cited February 2023
- ⁴ NHS Resolution. Five years of cerebral palsy claims. 2017. Available at: [Five-years-of-cerebral-palsy-claims A-thematic-review-of-NHS-Resolution-data.pdf](https://www.nhs.uk/press-releases/2017/05/23/five-years-of-cerebral-palsy-claims-a-thematic-review-of-nhs-resolution-data.pdf) Cited March 2023
- ⁵ Kirkup et al. Maternity and neonatal services in East Kent: 'Reading the signals' report. October 2022. Available at: <https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report> Cited February 2023
- ⁶ Ockenden et al. Final Report of the Ockenden review. DHSC. April 2022. Available at: [https://www.gov.uk/government/publications/final-Final-report-of-the-ockenden-ockenden-review - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/final-Final-report-of-the-ockenden-ockenden-review-GOV.UK(www.gov.uk)) Cited October 2022/February 2023
- ⁷ DoH. A maternity strategy for Northern Ireland 2012-2018 Available at: <https://www.health-ni.gov.uk/articles/maternity-strategy-northern-ireland-2012-2018> Cited February 2023
- ⁸ Lee, S.I., Azcoaga-Lorenzo, A., Agrawal, U. *et al.* Epidemiology of pre-existing multimorbidity in pregnant women in the UK in 2018: a population-based cross-sectional study. *BMC Pregnancy Childbirth* 22, 120 (2022). Available at: <https://doi.org/10.1186/s12884-022-04442-3> Cited February 2023
- ⁹ Kelly E, Lee T. Under pressure? NHS maternity services in England. Institute for Fiscal Studies 2017 Available at: https://ifs.org.uk/sites/default/files/output_url_files/BN215.pdf Cited February 2023
- ¹⁰ RCM. RCM Warns of midwife exodus as maternity staffing crisis grows. October 2021. Available at: <https://www.rcm.org.uk/media-releases/2021/september/rcm-warns-of-midwife-exodus-as-maternity-staffing-crisis-grows/> Cited February 2023
- ¹¹ SEHSCT. Temporary pause of births at Lagan Valley Hospital. March 2022. Available at: <https://setrust.hscni.net/temporary-pause-of-births-at-lagan-valley-hospital/> Cited February 2023

-
- ¹² Royal College of Midwives. Care outside guidance, 2022. Available at: https://www.rcm.org.uk/media/5941/care_outside_guidance.pdf Cited February 2023
- ¹³ NISRA Birth Statistics. Available at: <https://www.nisra.gov.uk/publications/birth-statistics> Cited February 2023
- ¹⁴ Health Committee. Fourth report - Safety of Maternity Services in England. Available at: <https://committees.parliament.uk/work/472/safety-of-maternity-services-in-england/> Cited February 2023
- ¹⁵ Information Analysis Directorate. Clinical / Social Negligence cases in Northern Ireland. DoH. December 2022. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/cscnc-ni-21-22.pdf> Cited February 2023
- ¹⁶ Lee, S.I., Azcoaga-Lorenzo, A., Agrawal, U. *et al.* Epidemiology of pre-existing multimorbidity in pregnant women in the UK in 2018: a population-based cross-sectional study. *BMC Pregnancy Childbirth* 22, 120 (2022). Available at: <https://doi.org/10.1186/s12884-022-04442-3> Cited February 2023
- ¹⁷ Kelly E, Lee T. Under pressure? NHS maternity services in England. Institute for Fiscal Studies 2017 Available at: https://ifs.org.uk/sites/default/files/output_url_files/BN215.pdf Cited February 2023
- ¹⁸ RCM. RCM Warns of midwife exodus as maternity staffing crisis grows. October 2021. Available at: <https://www.rcm.org.uk/media-releases/2021/september/rcm-warns-of-midwife-exodus-as-maternity-staffing-crisis-grows/> Cited February 2023
- ¹⁹ SEHSCT. Temporary pause of births at Lagan Valley Hospital. March 2022. Available at: <https://setrust.hscni.net/temporary-pause-of-births-at-lagan-valley-hospital/> Cited February 2023
- ²⁰ Kirkup et al. The Report of the Morecambe Bay Investigation. DHSC. 2015 Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf Cited February 2023
- ²¹ Ockenden et al. Final Report of the Ockenden review. DHSC. April 2022. Available at: <https://www.gov.uk/government/publications/final-Final-report-of-the-ockenden-Ockenden-review-GOV.UK-www.gov.uk> Cited October 2022 February 2023
- ²² Kirkup et al. Maternity and neonatal services in East Kent: 'Reading the signals' report. October 2022. Available at: <https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report> Cited February 2023

²³ RQIA Review of A Strategy for Maternity Care in Northern Ireland (2012-18) March 2017 Available at: <https://www.rqia.org.uk/reviews/review-reports/2016-2017/2016-2017/rqia-report-of-review-of-maternity-strategy-2012-2/> Cited February 2023

²⁴ DoH. A maternity strategy for Northern Ireland 2012-2018 Available at: <https://www.health-ni.gov.uk/articles/maternity-strategy-northern-ireland-2012-2018> Cited February 2023

A Strategy for Maternity Care in Northern Ireland 2012-2018. Available at [A Strategy for Maternity Care in Northern Ireland 2012 - 2018 \(health-ni.gov.uk\)](#) Cited February 2023

²⁶ Shaw, D., Guise, J. M., Shah, N., Gemzell-Danielsson, K., Joseph, K. S., Levy, B., Wong, F., Woodd, S., & Main, E. K. (2016). Drivers of maternity care in high-income countries: can health systems support woman-centred care? *The Lancet*, 388(10057), 2282-2295. Available at: [https://doi.org/10.1016/S0140-6736\(16\)31527-6](https://doi.org/10.1016/S0140-6736(16)31527-6) Cited February 2023

²⁷ Rich D. Psychological Impact of Pregnancy Loss: Best Practice for Obstetric Providers. *Clinical Obstetrics and Gynecology* 61(3):p 628-636, 2018. Available at: https://journals.lww.com/clinicalobgyn/Abstract/2018/09000/Psychological_Impact_of_Pregnancy_Loss_Best.24.aspx Cited February 2023

²⁸ DHSC. New ambition to halve rate of stillbirths and infant deaths. November 2015. Available at: <https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths> Cited February 2023

²⁹ Department for Health and Social Care, New maternity strategy to reduce the number of stillbirths, November 2017. Available at: <https://www.gov.uk/government/news/new-maternity-strategy-to-reduce-the-number-of-stillbirths> <https://www.gov.uk/government/news/new-maternity-strategy-to-reduce-the-number-of-stillbirths> Cited February 2023

³⁰ RCOG. Each Baby Counts 2015. Available at: <https://www.rcog.org.uk/eachbabycounts> Cited February 2023

³¹ NHS England. Saving Babies' Lives, 2015. Available at: <https://www.perinatal.org.uk/nhs-care-bundle.pdf> Cited February 2023

³² NHS England. Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, 2016. Available at: <https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/> Cited February 2023

³³ NHS England. Maternity Transformation Programme. Available at: <https://www.england.nhs.uk/mat-transformation/> Cited February 2023

-
- ³⁴ The best start: five-year plan for maternity and neonatal care. Available at: [The best start: five-year plan for maternity and neonatal care - gov.scot \(www.gov.scot\)](https://www.gov.scot)
Cited February 2023
- ³⁵ NMC Future midwife standards 2019. Available at:
<https://www.nmc.org.uk/news/news-and-updates/nmc-publishes-new-future-midwife-standards/> Cited February 2023
- ³⁶ DoH. A workforce plan for nursing and midwifery in Northern Ireland 2015 – 2025. DoH 2016. Available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/workforce-plan-nursing-midwifery-2015-2025.pdf> Cited February 2023
- ³⁷ Skills for Health (2009) Six Steps methodology to Integrated Workforce Planning. Available at: [Six Steps methodology to Integrated Workforce Planning - Skills for Health](#) Cited February 2023
- ³⁸ DoH. Health and Wellbeing 2026 – Delivering Together. Available at:
<https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together> Cited February 2023
- ³⁹ Nursing and Midwifery Task Group March 2022. Available at: <https://www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations> Cited February 2023
- ⁴⁰ Nursing and Midwifery Council (NMC) Future Nurse Future Midwife (FNFM) proficiency standards [future-nurse-proficiencies.pdf \(nmc.org.uk\)](https://www.nmc.org.uk/publications/future-nurse-future-midwife-fnfm-proficiency-standards) Cited February 2023
- ⁴¹ Public Health Agency. Phase 11 of its Delivering Care Midwifery Staffing Review, November 2022. Available at:
<https://www.publichealth.hscni.net/directorates/nursing-and-allied-health-professions/nursing/delivering-care> Cited February 2023
- ⁴² HSC Commissioning. Available at: <https://hscboard.hscni.net/our-work/commissioning/> Cited February 2023
- ⁴³ NIO. Secretary of State NI instructs the DoH to commission abortion services. Available at: <https://www.gov.uk/government/news/secretary-of-state-for-northern-ireland-instructs-the-department-of-health-to-commission-abortion-services> Cited February 2023
- ⁴⁴ MBRRACE-UK. The programme of work – maternal deaths. Available at: <https://www.npeu.ox.ac.uk/mbrance-uk/programme-of-work#maternal-deaths>
Cited February 2023
- ⁴⁵ MBRRACE-UK. The programme of work – stillbirths and infant deaths. Available at: <https://www.npeu.ox.ac.uk/mbrance-uk/programme-of-work#stillbirths-and-infant-deaths> Cited February 2023

-
- ⁴⁶ Liberati EG, Tarrant C, Willars J The SCALING Authorship Group, *et al.* Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation. *BMJ Quality & Safety* 2021;30:444-456. Available at: <https://qualitysafety.bmj.com/content/30/6/444> Cited February 2023
- ⁴⁷ [Quality Management System | Healthcare Improvement Scotland - Quality Management System \(ihub.scot\)](#) Cited February 2023
- ⁴⁸ NHS England. Implementing a reviewed perinatal quality surveillance model. December 2020. Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf> Cited February 2023
- ⁴⁹ Maternity Safety Programme Team, DHSC. Safer Maternity Care. October 2016. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf Cited February 2023
- ⁵⁰ NHS. Enhancing Board Oversight – A new approach to non-executive director champion roles. December 2021. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf
- ⁵¹ DoH. HSC Collective Leadership Strategy 2017. Available at: <https://www.health-ni.gov.uk/publications/hsc-collective-leadership-strategy> Cited February 2023
- ⁵² Brett Lockhart QC. Independent Neurology Inquiry June 2022. Available at: <https://www.neurologyinquiry.org.uk/news-centre/independent-neurology-inquiry-report-published> Cited February 2023
- ⁵³ Donaldson L. Right time, right place. 2014. Available at: <https://www.health-ni.gov.uk/topics/health-policy/donaldson-report> Cited February 2023
- ⁵⁴ Sandall et al. Staffing in maternity units: getting the right people in the right place at the right time. King's Fund 2011. Available at: <https://www.kingsfund.org.uk/sites/default/files/staffing-maternity-units-kings-fund-march2011.pdf> Cited February 2023
- ⁵⁵ Birthrate Plus. Supporting Safe Staffing in the Maternity Workforce. Available at: <https://birthrateplus.co.uk/> Cited February 2023
- ⁵⁶ Healthcare Improvement Scotland. Professional Judgement Tool. Available at: https://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools/pj_tool.aspx
- ⁵⁷ RCOG. Safe staffing in maternity tool. Available at: <https://www.rcog.org.uk/about-us/quality-improvement-clinical-audit-and-research-projects/safe-staffing-in-maternity-tool/> Cited February 2023
- ⁵⁸ Royal College of Obstetricians and Gynaecologists. Safer childbirth- minimum standards for the organisation and delivery of care in labour. London: RCOG, 2007.

Available at: <https://www.rcm.org.uk/media/2359/safer-childbirth-minimum-standards-for-the-organisation-and-delivery-of-care-in-labour.pdf> Cited February 2023

⁵⁹ Royal College of Anaesthetists. Guidelines for the provision of anaesthesia services for an obstetric population 2023. Available at: <https://rcoa.ac.uk/gpas/chapter-9><https://rcoa.ac.uk/gpas/chapter-9> Cited February 2023

⁶⁰ Royal College of Anaesthetists. Guidelines for the provision of anaesthesia services for an obstetric population 2023. Available at: <https://rcoa.ac.uk/gpas/chapter-9><https://rcoa.ac.uk/gpas/chapter-9> Cited February 2023

⁶¹ NHS improvement. Consultant Job Planning – a best practice guide. July 2017. Available at: <https://www.england.nhs.uk/wp-content/uploads/2022/05/consultant-job-planning-best-practice-guidance.pdf> Cited February 2023

⁶² NHS England and NHS Improvement. E-job planning the clinical workforce. September 2020. Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/09/e-job-planning-guidance.pdf>

⁶³ Six steps for electronic job planning adapted from NHS England and NHS Improvement: E-job planning the clinical workforce September 2020. Available at: <e-job-planning-guidance.pdf> (england.nhs.uk) Cited February 2023

⁶⁴ RCOG. Guidance on engagement of short term locums. 2022. Available at: <https://www.rcog.org.uk/media/tyrb4dfr/rcog-guidance-on-engagement-of-short-term-locums-in-maternity-care-august-2022.pdf> Cited February 2023

⁶⁵ RCOG. Improving Workplace Culture and Behaviours. Available at: <https://www.rcog.org.uk/careers-and-training/starting-your-og-career/workforce/supporting-our-doctors/improving-workplace-culture-and-behaviours/> Cited February 2023

⁶⁶ Civility Saves Lives. Available at: <https://www.civilitysaveslives.com> Cited February 2023

⁶⁷ GAIN Guidelines for Admission to Midwifery Led Units, 2018.

⁶⁸ RQIA Guideline for Planning to Give Birth at Home, 2019.

⁶⁹ NICE CG190 Intrapartum Care for Healthy Women and Babies 2014; Updated 2022. Available at <https://www.nice.org.uk/guidance/cg190> Cited February 2023

⁷⁰ [HSS\(MD\) 52 2022 - GUIDANCE ON PLACE OF BIRTH - IMMEDIATE ACTION REQUIRED.pdf](#) (hscni.net) Cited May 2023

-
- ⁷¹ The Supreme Court. *Montgomery v Lanarkshire Health Board*. March 2015. Available at: <https://www.supremecourt.uk/cases/uksc-2013-0136.html> Cited February 2023
- ⁷² Nursing Times. Normal birth campaign abandoned by Royal College. August 2017 Available at: <https://www.nursingtimes.net/news/policies-and-guidance/normal-birth-campaign-abandoned-by-royal-college-14-08-2017/>
- ⁷³ National Health Executive. NHS England scrap caesarean targets. February 2022. Available at: <https://www.nationalhealthexecutive.com/articles/nhs-england-scrap-caesarean-targets>
- ⁷⁴ Kirkup et al. Maternity and neonatal services in East Kent: 'Reading the signals' report. October 2022. Available at: <https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report> Cited February 2023
- ⁷⁵ MBRRACE-UK. Saving lives, improving mother's care. November 2022. Available at: [https://www.npeu.ox.ac.uk/assets/downloads/mbrance-uk/reports/maternal-report-2022/MBRRACE-UK Maternal MAIN Report 2022 v10.pdf](https://www.npeu.ox.ac.uk/assets/downloads/mbrance-uk/reports/maternal-report-2022/MBRRACE-UK%20Maternal%20MAIN%20Report%202022%20v10.pdf) Cited February 2023
- ⁷⁶ How do women with social risk factors experience United Kingdom maternity care? A realist synthesis. Rayment-Jones et al. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12446> Cited May 2023
- ⁷⁷ Maternity experiences of mothers with multiple disadvantages in England: A qualitative study. Available at: [Maternity experiences of mothers with multiple disadvantages in England: A qualitative study - ScienceDirect](#) Cited May 2023
- ⁷⁸ Rayment-Jones H., Murrells T., Sandall J. An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data — a retrospective, observational study. Available at: <https://pubmed.ncbi.nlm.nih.gov/25661044/> Cited May 2023
- ⁷⁹ MBRRACE-UK Saving Lives, Improving Mother's Care 2022. Available at: [MBRRACE-UK: Saving Lives, Improving Mothers' Care 2022 | Birth Companions](#) Cited February 2023
- ⁸⁰ Health and Personal Social Services Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015. Available at: [doh-pnor-guidance-v2.2.pdf \(health-ni.gov.uk\)](#) Cited May 2023
- ⁸¹ RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women. Available at: [RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women | RCOG](#) Cited May 2023
- ⁸² Perinatal Mortality Review Tool. Available at: <https://www.npeu.ox.ac.uk/pmrt> Cited February 2023

⁸³ RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland Available at: <https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf>
Cited October 2022 February 2023

⁸⁴ Health Safety Investigations Body (HSIB). Available at: <https://www.hsib.org.uk/what-we-do/maternity-investigations/>

⁸⁵ NHS England. Safety Culture. Learning from best practice. Available at: <https://www.england.nhs.uk/long-read/safety-culture-learning-from-best-practice/#5-psychological-safety> Cited February 2023

⁸⁶ Learning from excellence. Available at: <https://learningfromexcellence.com/> Cited February 2023

⁸⁷ NHS England. A Just Culture Guide. Available at: <https://www.england.nhs.uk/patient-safety/a-just-culture-guide/> Cited February 2023

⁸⁸ Health and Social Care Committee. Blame Culture in maternity safety failures prevents lessons being learnt. July 2021. Available at: <https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/156351/blame-culture-in-maternity-safety-failures-prevents-lessons-being-learnt-says-committee/>

⁸⁹ Dekker S, Oates A, Rafferty J. Restorative Just Culture in Practice: Implementation and Evaluation 2022. Available at: <https://doi.org/10.4324/9781003162582> Cited February 2023

⁹⁰ Northern HSC Trust. Working with you to inform acute maternity services. November 2022. Available at: <https://www.northerntrust.hscni.net/working-with-you-to-transform-acute-maternity-services/> Cited February 2023

⁹¹ The British Association of Perinatal Medicine (BAPM): Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021): A BAPM Framework for Practice. Available at: [Optimal Arrangements for Neonatal Intensive Care Units in the UK \(2021\) | British Association of Perinatal Medicine \(bapm.org\)](https://www.bapm.org/2021/01/optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021/) Cited February 2023

⁹² MBRRACE-UK Perinatal Mortality Report 2020. Available at: <https://timms.le.ac.uk/mbrpace-uk-perinatal-mortality/> Cited February 2023



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