Baseline Report

Development of Supported Care Pathway

Irish Maternity Services

October 2019

National Women & Infants Health Programme

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Chapter One Introduction

1.1 Background

As defined in the National Maternity Strategy, *Creating a Better Future Together*, *2016 - 2026,* a model of care broadly defines the way health services are delivered. It outlines best practice through the application of a set of principles across identified clinical streams and care pathways. The principles set out in the National Maternity Strategy seek to promote an integrated, multidisciplinary, evidence-based and team-based approach across all care setting.

A core component of the National Maternity Strategy's Model of Care "*is the establishment of a community midwifery service, as an outreach service from the hospital, working alongside the public health nurse services and general practice service, that will provide the woman with integrated care as close to home as possible*". This service was to be provided by a team of midwives, who will work as part of a wider multidisciplinary team and will rotate between the community and hospital, and support the woman through all stages of her care continuum. This service delivery approach will facilitate continuity of care, an element that was found to be lacking in the public consultation process undertaken as part of the Strategy development.

In describing the Model of Care, the National Maternity Strategy classifies pregnancy women/babies into three risk groups; normal risk, medium risk (requiring a higher level of oversight) and high risk (requiring a more intensive level of care, either throughout or at a particular stage of care). A choice of pathway of maternity care will be available to women based on this risk profile thereby enabling women to see the most appropriate professional based on their clinical need.

For women/babies classified as normal risk, the availability of the supported care pathway as provided by a community based midwifery service within a multidisciplinary framework is recommended. As set out in the Strategy, within this pathway, responsibility for the co-ordination of care to a woman will be assigned to a named Clinical Midwife Manager, and care will be delivered by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings.

Broken down into its three main components, the supported care pathway can be looked at from an antenatal, intrapartum and postnatal care period. At the time of publication of the National Strategy in 2016, of the 19 maternity services and units in the country, the following was the position in relation to the development and provision of the supported care pathway to women:

- Six maternity units and services were reported as having DOMINO services in place, a system of midwifery provided care which spans all three components of the supported care pathway,
- A further two services were reported as providing early transfer home (ETH) services, the postnatal care component, and
- Two services had in place midwifery-led units which enable delivery of the supported care pathway within specifically designed and dedicated clinical infrastructure on a hospital site.

1.2 Objectives of Baseline Exercise

The HSE's National Women and Infants Health Programme (NWIHP), in its role of driving and advancing the implementation of the National Maternity Strategy, targeted significant investment in additional midwifery resources across the 19 maternity services in 2018. The objective of this investment was to enable services to further develop and/or deploy the supported care pathway and to enhance senior midwifery expertise in the services by means of additional CMM2, CMS and AMP posts.

Late in 2018, it was determined by NWIHP that a baseline exercise would be undertaken of all 19 maternities services, with a view to:

- Reviewing the impact that the additional midwifery resources have had in maternity services
- Assessing the level of development of the supported care pathway across the 19 services ;
- Identifying both challenges and opportunities being encountered by maternity sites and units regarding midwifery provided care;
- Ascertain the priorities at local level regarding the further development of midwifery services; and
- Informing NWIHP at national level regarding future investment needed and actions required.

The output of this exercise would be a report which would enable the establishment of an initial national baseline of information on maternity services in Ireland further to the National Maternity Strategy that would have the potential to be further updated and developed going forward as required.

The baseline exercise was undertaken through a series of site visits by NWIHP personnel to each of the maternity services and units during the first half of 2019. During each visit face to face meetings were undertaken with the relevant Director of Midwifery and/or nominated members of their team and a tour undertaken of the maternity facilities.

NWIHP would like to take this opportunity to acknowledge with much thanks and appreciation the time and input of the Directors of Midwifery and their teams across the 19 services into this exercise.

Chapter Two Key Findings

2.1 Provision of Supported Care Pathway (Normal Risk)

The development of the supported care pathway within maternity services was reviewed across the 19 maternity services in the context of its three constituent parts – namely antenatal care, intrapartum care and postnatal care. This reflected the phased approach being adopted by maternity services in the process of developing and deploying this pathway subsequent to the National Maternity Strategy.

In exploring the development of this pathway across the system, it was identified that whilst all maternity services were actively working towards the delivery or further development of this care pathway, the journey undertaken by individual sites was reflective of their stage of development, investment levels, their size and capacity. Some maternity services commenced the deployment of supported care pathways over twenty years ago with the provision of DOMINO schemes, whilst others services had only commenced this journey in the previous 12 months at the point of the site visit.

2.2 Supported Care Pathway - Antenatal Care

Antenatal care is the care provided to women during their pregnancy. In approaching the development of a supported care pathway for the antenatal care period, maternity services will ordinarily adopt a phased approach whereby midwifery provided clinics are first established on their acute site, with these clinics once established either being transferred out to a community setting or being complemented by the establishment of additional midwifery clinics in the community setting.

The key findings in relation to the antenatal component of the supported care pathway are set out below:

Provision and Uptake

1. Sixteen of the nineteen maternity services are providing supported care pathway antenatal care. This represents a doubling of the number of maternity services (42% to 85%) which now offer this pathway to normal risk women subsequent to the publication of the National Maternity Strategy.

2. Of the women presenting to maternity services, it was reported that 10% to 35% of women were now being managed within the supported care pathway.[1]

[1] In one service which had introduced the supported care pathway subsequent to the publication of the National Maternity Strategy, a pilot was being undertaken such that women entering the supported care pathway would be cared throughout their pregnancy, including their intrapartum and postnatal period by a small defined cohort of midwives by means of a dedicated 24/7 roster. The structure and delivery of this pilot by necessity reduced the number of women who could be managed in this manner.

Demand for Supported Care Pathway

3. Demand from women for access to the supported care pathway was mixed across sites, with some sites reporting that they were nearing or had reached capacity on this pathway based on current resources available, whilst others reported that capacity remained and that there were actively seeking to increase uptake of clinically appropriate women. In relation to this latter cohort of sites, multiple factors were identified as to why uptake may not be optimal, including awareness of women that this option of care was available, ability of services to advertise and promote the availability of the supported care pathway and buy in and promotion of this pathway at both primary and secondary care level.

Clinical Governance Model

4. The clinical governance model in place in the sixteen units differed in terms of whether the woman was recorded and identified as being under the clinical care of a designated midwifery team and/or named senior midwife (ordinarily an AMP where this model was present) or whether the woman was recorded and identified as being under the clinical care of a named consultant. In relation to this latter model, this named consultant was either the designated medical lead for the supported care pathway in a given site or was the consultant under whom the patient was registered at her booking clinic. It was noted that in general, services that had in place the supported care pathway longer tended to have the former model whilst services with newly developed pathways tended to have the latter model.

Clinical Risk Assessment

5. All sixteen services had in place locally developed and agreed clinical risk profiling criteria by which women would be assessed from a clinical risk perspective as to their appropriateness for management within a support care pathway. As confidence and experience grew on individual sites regarding the delivery of care within the supported care pathway, these criteria on a number of sites were noted as being actively reviewed in terms of whether scope existed for their expansion in a clinically appropriate and safe manner for example BMI parameters.

6. In terms of women being assessed and deemed clinically appropriate for the supported care pathway, two types of arrangements were identified across the 16 units. In more well established services, for example in the Dublin region, women were assessed at their booking in clinic as to their clinical appropriateness and if deemed suitable, were directly placed on the supported care pathway by the relevant midwife. In other areas, particularly in those services where the service is relatively newly established, further to their booking in clinic, women were required to be assessed and signed off as clinically appropriate for the supported care pathway by the relevant medical team. It is anticipated that with time, these latter sites will transition towards the former model.

Access to Supported Care Pathways

7. In terms of women seeking and accessing the supported care pathway subject to being assessed as being of normal risk, three primary types of arrangements were identified. The first being more apparent in the well-established services whereby women themselves would seek direct access to same, the second being where women further to being assessed within the maternity service would be offered the option of care within the supported care pathway i.e. woman opts in, and the last being where women further to assessment within the maternity service would be automatically placed on the supported care pathway but has the option to withdraw from same i.e. woman opts out.

Referral to Maternity Services

8. With the exception of the Dublin region, women on the whole are referred by their GPs to their local maternity services for a booking in clinic appointment. Within the Dublin region, women tend to self-refer to the maternity service. In this context, it was identified, particularly by those services with newly established midwifery delivered antenatal care, that communication with local GPs was essential and that their buy-in and support for the supported care pathway was critical. These GPs have the first contact with pregnant women and have that critical initial discussion regarding care options available and suitable.

Maternity and Infant Care Scheme

9. In all sixteen units, it was reported that all women accessing the antenatal component of the supported care pathway were engaged in a shared model of care with their GP, as provided for by the *Maternity and Infant Care Scheme*.

Escalation Processes

10. All units providing the supported care pathway had in place defined escalation and de-escalation process in relation to the management of a women's changing clinical risk profile as her pregnancy progressed. In some units this was the named consultant under which the patient was registered, in others referral would be made to the consultant on-call. Depending on the outcome of the clinical assessment, the patient would either remain under the direct care of the consultant and their medical team i.e. transition to the assisted or specialised care pathway, or be referred back to continue their care in the supported care pathway. The importance of a smooth transfer between pathways of care was recognised in all services.

Community Based Midwifery Clinics

11. Regarding the direct delivery of midwifery care in the community, fifteen of the sixteen maternity services in addition to midwifery provided clinics on their acute sites, were actively delivering midwifery provided antenatal clinics in the community. In some of the more-well established services e.g. Cork, Rotunda, Holles St., there were multiple locations to which the midwifery teams travelled, with all services and units actively identifying plans to further extend and expand their outreach services. A key challenge identified by a number of maternity services in this regard was securing consistent and on-going access to

HSE community based facilities, with newly developed primary care centres being identified as the ideal location for this type of care for pregnant women. This access issue was particularly problematic outside the Dublin region.

Community Based Booking In Clinics

12. As part of the supported care pathway, 10 maternity services were providing booking-in clinics for women in the community. Whilst the current resources available to these clinics still required the majority of women to present to the hospital site for their dating scan, the ultimate ambition of these services is that dating scans will be provided as part of the community booking in clinics. This would result in normal risk women who are accessing midwifery provided care in the community having to attend the hospital site only for their anomaly scan as part of their antenatal care package.

Key Findings
Supported Care Pathway Antenatal Care

- 16 of the 19 maternity services are providing the supported care pathway.
- 10% – 35% of women are managed in the supported care pathway.
- Two primary models of clinical governance – midwifery model or consultant model.
- All 16 services have locally agreed clinical risk profiling criteria.
- Three modes for accessing pathway – women seek directly, opt in or opt out.
- All women in the supported care pathway engage in a shared model of care with their GP.
- All 16 services had in place defined escalation and de-escalation processes.
- 15 of the 16 services had a community based presence.
- 10 of the 16 services provided booking in clinics in the community

2.3 Supported Care Pathway - Intrapartum Care

Intrapartum care is the care provided to women and their babies during labour and immediately after birth. The key findings in relation to the intrapartum component of the supported care pathway are set out below:

Midwifery Led Units (MLUs)

13. There are two midwifery led units in place in the Irish maternity services – these being the units present in Drogheda and Cavan. These units were established and resourced with dedicated 24/7 teams of midwives that support the woman through all three stages of her care continuum – antenatal, intrapartum and postnatal. This model of service delivery facilitates continuity of care to women throughout, such that women are cared for and managed by midwifes during labour who will be known to them from their antenatal care period.

Alternative Continuity of Care Models

14. In the remaining maternity services, it was collectively acknowledged that from a resource perspective it was simply not feasible at present for those services to have in place a

dedicated and separate 24/7 roster of midwives so as to ensure this continuity of care model in relation to the intrapartum period. In light of this acknowledged challenge, two primary approaches were identified across the remaining fourteen units that were actively providing the supported care pathway. The first approach, present in the larger maternity units, was that one midwife from the supported care pathway team would be rostered in either the emergency unit or in the delivery suite of the maternity service on a 24/7 basis. This midwife as required would then be assigned to any woman presenting to give birth who had been managed in the supported care pathway, thereby ensuring a continuity of care model for the labouring process.

The second approach, being developed and deployed in the medium and smaller services, was focused on enabling all midwives to ultimately rotate through the supported care pathway team, thereby ensuring awareness, engagement and knowledge amongst the full midwifery team as to model of care within this pathway and the birthing philosophy underpinning same. This would enable women to be cared for in the delivery suites by midwives who would be aware of their care package and their expectations and ambitions for the labouring process.

Home Births

15. In relation to the provision of homebirths, there are three primary care pathways for same. The HSE National Home Birth Service is provided on behalf of the HSE by self-employed community midwives, with fourteen of the nineteen units reporting that they had engagement with this service in terms of women being signed off as clinically appropriate for same and/or being reviewed upon referral from SECMs. The second pathway is the direct provision of homebirths by maternity services, with three maternity services directly providing a homebirth service under the auspices of their supported care pathway. The third pathway is the provision of homebirth care by private midwifery services, which no HSE delivered or HSE funded maternity service has any role or remit in.

Shift Leaders

16. The provision and availability of senior midwifery decision makers at CMM2 level for each of the nineteen delivery wards on a 24/7 basis is an objective which the public maternity services are working towards. At the point of the baseline exercise being undertaken, sixteen maternity services had such 24/7 senior midwifery decision makers arrangements in place. It should be noted that these senior midwifes, referred to as shift leaders, were not supernumerary in all sixteen sites.

Key Findings
Supported Care Pathway - Intrapartum Care

- 2 MLUs in place with designated 24/7 midwifery staffing for continuity of care.
- Two other approaches identified so as to enable continuity of care model – rostering of community midwives in emergency units and delivery suites or rotation of midwives through supported care pathway team.
- 14 services engage with the HSE National Homebirth Service
- 3 services provide homebirth services directly.

- 16 maternity services have available on a 24/7 basis senior midwifery decision makers at CMM2 level for their delivery wards, not all of whom are supernummary.

2.4 Supported Care Pathway - Postnatal Care

Postnatal care is the care provided to women further to the birth of their baby. Within the supported care pathway, it is envisaged that the community midwifery team will provide postnatal care to support the mother and family's transition home, thereby ensuring continuity of care into the postnatal period into the home prior to handover to public health nursing services.

The key findings in relation to the postnatal component of the supported care pathway are set out below:

Early Transfer Home (ETH) Services

17. In relation to Early Transfer Home (ETH) services, 11 maternity services had such a service in place which enabled and supported women and their babies who were clinically appropriate to be discharged home within 24 hours of giving birth. These women remained under the care of the midwifery team as part of the supported care pathway for up to a week. As required this period of care could be extended to 10 to 14 days if deemed clinical appropriate and necessary.

18. This ETH care package across the 11 service ordinarily consists of anywhere between one to five home visits as deemed required and phone support and engagement. The majority of services providing this service have defined a geographical area within which they provide this service. Of the eleven maternity services providing ETH, some only make this service available to women who were managed in the supported care pathway during their antenatal period, whilst others make this service available to all clinically appropriate mothers and their babies regardless of their antenatal care pathway.

Access to ETH

19. Of the 11 sites providing ETH, the percentage of women accessing same various from approximately 5% upwards to 30% in some services.

Future Direction of ETH Services

20. In terms of ETH services and their development across all maternity services, it is acknowledged that this is a particularly resource intensive services. Discussions are underway in a number of services at local level as to how best to deploy midwifery ETH resources in terms of ensuring that women most in need of midwifery care in their postnatal period have access to it post discharge. As this discussion develops, it is envisaged at national level that alternative care packages of ETH will develop around the country. Such packages may comprise of a mix of home visits, phone support and community based midwifery provided postnatal clinics tailored to the needs of individual women. The criteria for women eligible to access this midwifery provided community based postnatal care is also under discussion and review within maternity services. Again at national level it is expected

that with time these criteria will widen to potentially include those women who may for example have had a C-section or a challenging birth and who would benefit immensely from having access to midwifery expertise for a period post discharge. As such, with time it is expected that this care will be driven primarily by the need of women for continued midwifery care in the community after giving birth irrespective of the duration of their postnatal care on the acute site.

Key Findings
Support Care Pathway - Postnatal Care

- 11 maternity services have in place early transfer home (ETH) services.
- ETH package consists of anywhere between 1 to 5 visits depending on needs of woman.
- ETH package can be extended beyond 7 days as and when needed.
- The percentage of women accessing ETH services ranges from 5% upwards to 30% across the 11 services.
- ETH under review across services with a view to how delivered and to whom.

2.5 Infrastructure

As part of the baseline exercise, high level data was also collected by NWIHP in relation to the infrastructure available within maternity services. The majority of site visits also entailed a tour around existing facilities including delivery suites, antenatal and postnatal wards, EPAU etc. This component of work does not purport to be an audit of infrastructure, nor was it designed to provide and/or inform the development of a detailed capital investment proposal regarding maternity services in Ireland.

Notwithstanding these limitations, there is considerable variation across the 19 maternity services as to the standard, comfort and environment that services are delivered. It is clear within a number of services that investment is required for much needed upgrading and refurbishment works. The area of maternity infrastructure is one that will require further going forward so as to ensure that both women and their families and staff have access to the same basic quality of infrastructure irrespective of location.

The key findings in relation to infrastructure are set out below:

Delivery Suites

21. Across the 19 maternity services and units, there are a total of 114 delivery suites, with the number of suites ranging from two up to twelve across the nineteen maternity units.

Home-Away-From-Home Facilities

22. As part of the roll out of the supported care pathway, and in line with the National Maternity Strategy, the potential development and provision of home-away-from-home delivery suites was being reviewed actively across a number of services. At the time of undertaking site visits, eleven designated home-away-from-home delivery suites were identified across maternity services (including the four located in the two MLUs in the north east), resulting in five of the six hospital groups having maternity services with such delivery facilities available.

23. These home-away-from-home facilities were furnished and equipped with an array of birthing aids but the level and range of such aids varied significantly across sites, with almost all relevant services identifying a desire to invest further in birthing aids.

24. The provision of home-away-from-home delivery suites was being managed within maternity services by means of refurbishment of existing traditional styled delivery suites and/or by refurbishment of clinical areas adjacent to or located in the existing delivery ward.

25. In discussions with sites and services, whilst a number had identified and worked up proposals for the development of home-away-from-home facilities on their sites, the availability of the required capital funding to support same was identified as a key limiting step.

26. In reviewing the home-away-from-home suites with local sites and services, it was identified that there existed two primary approaches to the development of these delivery suites. In some services, these facilities had been approached and designed in such a way that supporting medical equipment was kept at an absolute minimal in the room, with women requiring transfer to another delivery suite if there was an escalation of risk identified during labour. In other services, facilities had been designed in such a way that the full array of medical equipment was available, albeit hidden by the design, and that the women did not require transfer to another suite if there was an escalation of risk identified during labour.

Birthing / Labour Pools

27. From a labour / birthing pool perspective, only ten such pools were identified across the 19 maternity sites and services, four of which were based in the midwifery led units in the north east. Of these ten pools, one was actively used as a birthing pool as part of a structured audited programme, whilst the remainder were used for labouring.

28. In conjunction with the development of home-away-from-home delivery suites, a number of services were actively reviewing and exploring the possibility of implementing labouring pools in their services. A number of services were significantly constrained in this manner, not only in terms of the additional funding required to enable same, but also in terms of space requirements and/or the ability of existing infrastructure to safely support the weight of a pool.

Beds

29. From a bed perspective, at the time of the undertaking of site visits, a total of 978 beds were identified within the 19 maternity services from an antenatal and postnatal perspective. Availability of beds ranged from 26 to over 100 depending on the size and scale of the maternity service. In the larger units these beds were located and managed in designated and separate antenatal and postnatal wards, whilst in smaller and medium sized unit, the beds were managed as the totality of beds available to maternity services. A such in these services the number of beds designated antenatal or postnatal could flex up or down

depending on the needs of patients. In a small number of services, beds were also shared with gynaecology services.

Emergency Theatre Access

30. Eight of the nineteen maternity services had access to a designated, protected and resourced emergency theatre for maternity services. As could be expected, these arrangements were in place in the larger to medium sized maternity services. The remainder of services reported that they had priority access for emergencies to the allocated elective maternity / gynaecology theatre on site and /or the general emergency theatre on site with the required communication processes in place to manage this with theatre personnel. Emergency theatre facilities ideally should be located adjacent or on the same floor of the service's delivery suites. In services where the infrastructure did not enable this arrangement, services reported systems in place to enable rapid presentation to theatres including dedicated lifts from the delivery suites and/or over-ride processes for shared lifts.

Elective Theatre Access

31. In relation to the provision and management of elective maternity surgical services, the nineteen services across the country had access to a total of 31 theatres. These theatres, with one exception, were also being utilised to provide gynaecology surgical services in the context that the same team of specialists on most sites provide both surgical services. In a very small number of sites, the designated maternity / gynaecology theatre is also used and accessed by other surgical specialties during the week.

Key Findings
Maternity Infrastructure

- Significant variations exist across the 19 services as to the standard of infrastructure available.
- A total of 114 delivery suites are available within maternity services in Ireland.
- 11 home-away-from-home delivery suites available in Ireland including those in MLUs.
- Ten labouring pools available in maternity services, only one used for birthing.
- A total of 978 IP beds identified across 19 services for antenatal and postnatal care.
- 8 of the 19 services had access to a designated, protected and resourced emergency theatre.
- Provision of elective maternity surgical services managed in a total of 31 theatres.
- All but one of these theatres also utilised to provide gynaecology services, with some also accessed by other surgical specialities.

2.6 Scanning Services

Dating Scanning Services

32. All 19 maternity services reported 100% provision of dating scans to women. The only exception highlighted was in relation to women who presented late in their pregnancy (circa >16 weeks gestation) where it would be determined that it would be more practical to

proceed with the provision of an anomaly scan at the twenty week point of care rather than a dating scan followed shortly by an anomaly scan.

Anomaly Scanning Services

33. In relation to the provision of the twenty week anomaly scan, significant inroads have been made by maternity services regarding the provision of this service. In 2016, only seven of the nineteen maternity services provided this scan universally, with a further seven offering this scanning service if clinical indicated. With the approval and appointed of additional sonographers within maternity services, at the point of the site visits, fifteen maternity services were providing anomaly scan to all women, with the remaining four sites actively training and/or recruiting approved additional sonographers with the objective of reaching 100% compliance. In the interim these services were providing clinical indicated anomaly scanning to women being managed in their services.

Key Findings
Scanning Services

- All 19 services reported 100% provision of dating scans to women.
- 15 services are providing anomaly scanning to 100% of women presenting.
- 4 remaining services are providing anomaly scanning based on clinical indications and are actively working towards 100% compliance.

2.7 Specialised & Senior Midwifery Care

Advanced Midwifery Practitioner Resources

34. The availability and development of advanced midwifery practitioners within maternity services was identified as being significantly limited. Across all 19 maternity services and units, only 13 such posts were identified with a number of these posts in the area of neonatology care as distinct from maternity care. Twelve maternity services do not have in place any AMP resources.

35. Where available, AMPs had driven service development and delivery in the areas of supported care pathway, assisted care pathway, emergency care, women's health and neonatology. The impact of AMPs in the smaller units where available was particularly noteworthy as they had enabled the delivery of a model of care which ensured that women experienced a seamless pathway of care with minimal fragmentation and duplication. Without exception, all nineteen maternity services identified further development of these senior midwifery roles as being critical in terms of underpinning and enabling the further roll out of the National Maternity Strategy. It is envisaged that in the smaller units, AMP roles will focus on supporting and enabling further development of the supported care pathway, whilst carrying a caseload from the assisted care pathway. In the larger units, it would be envisaged that AMPs would focus and specialise in specific components of the assisted and specialised care pathways.

Clinical Midwifery Specialist Resources

36. All 19 services and units had CMS posts, with the number of such posts available to each service ranging from three upwards, with some of the larger maternity services having fourteen such posts. The range of specialist clinical areas covered by these CMS postholders included ultrasonography, bereavement, perinatal mental health, lactation, diabetes, clinical skills and practice development. In the larger services CMS postholders also specialised in areas such as teenage pregnancy, infectious disease, haematology and foetal medicine.

37. Given the variation of the numbers available across the 19 services, there were significant inconsistencies across services as to the availability of expertise in areas that would be considered central and core to the provision of all maternity services irrespective of size, for example in the areas of lactation and practice development.

Key Findings
Specialised & Senior Midwifery Care

- Across the 19 services, there are only 13 AMPs some of which are in neonatology.
- Twelve maternity services do not have any AMP resources.
- Further development of AMP role in maternity services identified as critical.
- All 19 services have CMS posts, with numbers ranging from three upwards to 14 per service.
- Significant inconsistencies across services as to core CMS roles e.g. lactation.

2.8 Specialised Care Pathways Available Within Maternity Services

Scope and Range of Pathways

38. In terms of the provision of specialised care pathways available within maternity service, as is entirely appropriate the scope and range of same was dependent on the presence and/or availability of expertise both within the maternity service itself and within the wider clinical community present on the site. As would be expected, the larger the maternity service, the greater the range of specialised care pathways available. As such the range of specialised care pathways available in maternity services across the 19 units included bereavement, perinatal mental health services, lactation, endocrinology, multiple pregnancies, anaesthetics, teenage pregnancies, foetal medicine, infectious diseases, VBAC, cardiology and high risk management

Referral Pathways

39. All nineteen maternity services reported having in place structured and established referral pathways with tertiary centres for the care and management of the woman and/or baby. Depending on the clinical circumstances these referral pathways could involve the referral of the woman from a maternity service to a tertiary maternity service for the management of pregnancy related complications or risk. Alternatively women can be referred from a maternity service to specialised adult or paediatric services for the management of existing or presenting medical conditions during the pregnancy for example renal dialysis services, cardiac services, foetal cardiac services, maternal-foetal medicine service, infectious disease services, cystic fibrosis management etc.

Key Findings
Specialised Care Pathways

- The scope and range of specialised care pathways within individual maternity services, as is entirely appropriately, is dependent on the availability of expertise within the service and the wider clinical community.
- Examples of specialised care pathways include bereavement, lactation, multiple pregnancies, teenage pregnancies, infectious disease and foetal medicine.
- All 19 services reported having in place structured referral pathways with tertiary centres for the care and management of the woman and/or baby as clinically required.

2.9 Essential Support & Ancillary Services

Specialist Perinatal Mental Health Services

40. On foot of the Model of Care for Specialist Perinatal Mental Health launch in 2017, all maternity services have been configured into hub and spoke models for the provision of this service. Investment in this area has enabled all maternity services to report that they have in place or are actively recruiting clinical midwife specialist expertise in the area of perinatal mental health, with hub centres being further supported by the appointment of additional consultant posts.

Specialist Bereavement Services

41. In the area of bereavement, further to the publication of the National Standards for Bereavement Care Following Pregnancy Loss & Perinatal Death, investment in this area has enabled all maternity services to report that they have in place clinical midwife specialist expertise in this area. With funding support from a range of sources including the Irish Hospice Foundation, donations and HSE funding, the development and provision of dedicated, specifically designed bereavement rooms in each of the 19 services is well underway.

Medical Social Work Services

42. The provision and availability of medical social work expertise is a key component of the delivery of a holistic, comprehensive maternity service. The requirements for access to this support were reported as significant as maternity services try and manage increasingly complex set of circumstances presenting including homelessness, child protection reporting requirements, asylum seekers care requirements, socially at risk women, women at risk of domestic violence, substance misuse etc. Of the nineteen maternity services, twelve have access to on-site medical social work expertise and support, one has access only in emergencies, whilst six maternity services do not have access to on-site medical social work services.

Dietetic Services

43. Dietetic expertise was reported as an increasingly required support service for the provision of quality maternity care arising from the increase in BMI rates in women presenting to maternity services, increased presentation of women with diabetes and/or at risk from

gestational diabetes and the strategic priority as identified in the National Maternity Strategy regarding empowering women to improve their own health and wellbeing. Of the nineteen services, nine services reported having access to dietetic services, seven reported having very limited access, one service had access on a case by case basis, one only had access for inpatients, whilst one service had no access at all. Many services where available were provided from the general dietetic resource pool and as such were not dedicated or specifically identified for maternity servics, so were accessed from teams acknowledged to be under pressure from other service demands.

Drug Liaison and Addiction Services

44. The provision of drug liaison and addiction services across the nineteen maternity units varied. A small number of services, particularly in the larger units, had developed specific in house expertise. Other maternity services accessed expertise and support in this area via their medical social work colleagues, whilst other units had developed collaborative working relationships with key voluntary/charitable agencies in their surrounding catchment areas. For some maternity services their only avenue was to refer the woman to their GP for the appropriate management and follow up. As part of the engagement with maternity services, it was acknowledged that expertise and resources in the area of drug and addiction services was not required in each individual maternity services, but rather a co-ordinating clinical resource at hospital group level is required in the first instance to support maternity services manage this complex patient cohort across a network of services.

Smoking Cessation Services

45. From a smoking cessation service perspective, all 19 maternity services akin to all other services, reported having access to HSE wide supports in this area, for example the QUIT programme. In terms of specialist services for pregnant women in the area of smoking cessation over and above these HSE wide supports, 12 services reported having access to on-site expertise in this area. On the whole, this on-site resource was available to all hospital based services and as such was not dedicated or identified solely for maternity services, with the exceptions being in some of the larger standalone maternity hospitals.

Practice Development Resources

46. The availability of a dedicated practice development resource is key in terms of enabling and supporting clinical teams to maintain and develop their skill sets, ensuring mandatory training is delivered and certified, providing robust and structured induction courses for new entrants and supporting recruitment and retention initiatives. At the point of the baseline review being undertaken, four maternity services did not have available to them dedicated CMS in practice development, whilst one service had access on a short term basis.

Quality Resources

47. In terms of assessing the support available to maternity services at local level to develop and drive a quality agenda within their services, as part of this exercise maternity services were asked whether they had access to a designated quality lead for their service. Whilst all units and services had access to the on-site quality and risk department, with the level of

structured engagement with these departments varying. Five services reported having a named, identifiable quality resource that would engage with the service in terms of supporting, enabling and reviewing quality initiatives that would be sought and identified by the relevant clinical teams.

Key Findings

Essential Support & Ancillary Services

- All 19 services have CMS posts in perinatal mental health.
- All 19 services have CMS posts in bereavement.
- Access to medical social work expertise is extremely variable across the services, with six maternity services having no such access.
- Access to dietetics expertise is extremely variable across the services, with need in this area continuing to grow.
- A variety of arrangements are in place across the 19 services regarding the provision of drug liaison and addition services, a co-ordinating resource at hospital group was identified as required in this area.
- All services have access to generic supports in the area of smoking cessation, with 12 services having access to on-site, albeit hospital wide, expertise in this area.
- Four maternity services did not have practice development resources, whilst one service had such a post on a short term basis.
- Five services reporting having structured access to a named, identifiable quality resource that would support and enable clinical teams to develop and implement quality initiatives.

Chapter Three Conclusion

3.1 Summary

The publication of the National Maternity Strategy, *Creating A Better Future Together 2016 to 2026*, provided for the first time ever in Ireland a strategic roadmap for the development and delivery of maternity services in Ireland built around a defined Model of Care. A core principle of this Strategy was that as distinct from most other models of healthcare, maternity care is intended to support a normal physiological process, involving pregnancy and childbirth. As such women should be offered choice regarding their preferred pathway of care in line with safety, their clinical needs and best practice. The pathway of care to be made available to women presenting with normal risk is the supported care pathway.

As set out in this report, significant inroads have been made across the public maternity services regarding the development of a supported care pathway across the three key components – antenatal, intrapartum and postnatal care. Some services commenced this journey almost 20 years ago and have led the way in how this pathway should be structured and delivered whilst others are only commencing the journey in recent times.

In providing the supported care pathway, each service must work within the opportunities and challenges as present in their own services and their surrounding environment, thereby inevitably leading to local innovations and approaches as to how midwifery provided care is developed. At the core of any change management programme is the vision and commitment of individuals, teams and sites.

Across all 19 maternity services, notwithstanding the challenges which existed within each, many of which are highlighted throughout this report, the energy of this vision and commitment was self-evident. Each service was determined to continue to develop and expand its midwifery provided services, whether by means of additional community based clinics, provision of booking in clinics directly in patient's homes, scanning services in the community, availability of components of the supported care package to women traditionally deemed clinically unsuitable, development and deployment of specifically designed wrap around services for socially at risk women etc. Responding with commitment to the needs of women as best known at the front line, will with luck and with the required supports provided, drive midwifery provided maternity care beyond that even envisaged within the National Strategy.

With any type of change programme, additional opportunities and innovations are enabled and this was clearly visible within maternity services. These included the development of midwifery provided specialised reflection services across a number of sites which provided women who had experienced a difficult birth the opportunity and time to reflect on same with the input and support of a dedicated midwife and other teams members as required, the further enhancement and development of VBAC clinics and supports and the development of a nurse provided neonatal clinic in the community which dovetailed with midwifery provided clinics which supported and gave confidence to families caring for a neonate recently discharged from a special care baby unit, to name but a few.

3.2 Next Steps & Future Actions

The undertaking of the baseline exercise has provided the National Women and Infants Health Programme with a wealth of information and data supplied by front line providers as to the where maternity services are in Ireland in relation to the development and deployment of the supported care pathway. As part of this exercise, and as set out in this Report, information was also sought and provided in relation to a number of other areas including infrastructure, support services etc.

At local level, work will continue to drive forward this change agenda as services continue to implement the Model of Care as defined in the National Maternity Strategy. At national level, with a view to supporting and enabling this work across the 19 maternity services, NWIHP have identified a suite of actions informed by this exercise which will form part of its work programme during the course of 2019 / 2020, which include:

- Development of submission for 2020 Estimate Process informed and underpinned by the key findings of this exercise and the challenges identified therein including additional AMP, shift leader and CNS posts and essential ancillary support staff including allied health professionals;
- Develop and implement a communication strategy which will enable women and their families to easily access information as to the range of care pathways available in their local maternity services, will facilitate services to showcase what they provide, will promote the role of the midwife and will increase awareness of the Model of Care amongst the public and primary care providers;
- Support the provision of home-away-from-home facilities in a number of sites where modest support is required;
- Work at national level to enable and support maternity services at local level to gain secure and regular access to new and recently developed primary care centres in their vicinity;
- Identify and support local initiatives that could be applicable to other services that promote midwifery care e.g. Hopscotch;
- Support and engage with services as to the review of the structure and delivery of early transfer home services so that going forward this care is available based on women's need as distinct to length of time of postnatal care on acute site;
- Promote and support the development and roll out of the National Patient Experience Survey within maternity services;
- Integration of the HSE Homebirth Services within the acute sector; and
- Roll out of the National Healthcare Communication Programme to maternity service providers.