Development of this strategy was commenced by the Eastern Regional Health Authority in 2004. On 1 January 2005, the Health Service Executive was established with full operational responsibility for the delivery of health services in Ireland.

The former Eastern Regional Health Authority became part of the Health Service Executive on 1 January 2005 and was known as Health Service Executive Eastern Region. From 15 June 2005 formal unification of the health system in Ireland occurred creating a national health service, and Health Service Executive Eastern Region was amalgamated into the national service.

MATERNITY SERVICES IN THE EASTERN REGION - A STRATEGY FOR THE FUTURE 2005
Every living community begins with mothers and babies. Their well-being is, therefore, important not only for them, but also for the future common good of the entire population. This is the basis for undertaking a significant review of what is required in order to provide the best possible maternity services for the community in the designated area.

We welcome the publication of this report Maternity Services in the Eastern Region - A Strategy for the Future 2005-2011. The number of births taking place in the eastern region has increased steadily in the last 10 years. It is important that health and social services have the capacity to respond to this increased demand. The strategy provides us with valuable information for action in this regard.

The 'Eastern Region' of the title includes the three Dublin maternity hospitals, which provide obstetrics, gynaecology and neonatology services for women and infants in the greater Dublin and surrounding areas. All three are also tertiary referral centres for specialist treatment. It is clear that the maternity hospitals and the other providers of healthcare, education and information must collaborate if they are to be effective. An important element of this strategy is that it has been developed by a steering group, established in 2003 by the former Eastern Regional Health Authority and the Joint Standing Committee of the Dublin Maternity Hospitals. It has been written in the context of developments in maternity and health care in Ireland and internationally. It is imbued with the necessity for a collaborative approach.

This review has regard to the response of women who have given birth and of those who have provided maternity services in the region in the recent past. This is an important aspect of the contents.

While the Irish health service is facing many challenges, childbirth is not a medical procedure that can be classified as elective and deferred, if facilities are over-stretched. The strategic organisation of maternity services in the eastern region is, therefore, a matter of urgency and recognition of that urgency is a fundamental element of this review.

It is hoped that the scope, contents and approach of this review will inspire a speedy and constructive response from both policy makers and funders of services. The health of the people of Ireland and that of future generations so require.

Mr. Michael Lyons

Dr. Miriam Hederman O'Brien
Chair
Joint Standing Committee of the Dublin Maternity Hospitals

Mr. Michael Lyons
knowledgements

This document was prepared through the collaboration of the Planning Commissioning and Change Directorate, Nursing and Midwifery Planning and Development Unit, and Department of Public Health, HSE - Eastern Region.

The Health Service Executive (HSE) - Eastern Region gratefully acknowledges the work of the Strategic Planning for Maternity Services and Women's Health Steering Committee for their expert guidance in the development of this strategy. The contribution of the Irish College of General Practitioners to the development of the strategy is also acknowledged.

The comprehensive work undertaken by the Department of Public Health, HSE - Eastern Region, to assess the current and projected demand for maternity services has been invaluable in informing this strategy. The HSE - Eastern Region also acknowledges the work of The Women's Health Council in enabling the voices and views of the many women using maternity services and those providing services to inform the strategy.

Professional advice on the future development of services and related workforce planning for nursing and midwifery was provided by the Nursing and Midwifery Planning and Development Unit, HSE - Eastern Region.
Executive Summary

Maternity services are an extremely important part of health care in Ireland. The quality of maternity services determines, to a significant extent, the standard of health of the Irish population.

Approximately 40% of births nationally per annum take place in the three maternity hospitals in the eastern region, The Rotunda Hospital, National Maternity Hospital and Coombe Women's Hospital. All three hospitals act as national tertiary referral centres for women and babies in need of specialist treatment.

Regional activity is exceeding maximum capacity levels as service providers continue to develop and refine their services in order to promote the best possible outcomes for women and their babies.

The former Eastern Regional Health Authority, now known as Health Service Executive - Eastern Region, and the Joint Standing Committee of the Dublin Maternity Hospitals established a steering group in 2003 to identify current and future impact on service developments and establish a strategy for the future development of maternity services in the region.

To assist this process, a needs assessment was undertaken that included a mapping exercise on births and also birth projections up to 2011. In addition, The Women's Health Council was commissioned to undertake a consultative process on maternity service needs for the strategy.

This strategy document focuses on the key findings of these reports:

- **Increasing activity**
  The population of the eastern region increased by 8% between 1996 and 2002 and it is expected to increase by 9% more than the national average rate by 2011. The most recent birth projection figures indicate that births to women in the eastern region and Meath will increase by 820 (5%) between 2003 and 2006 and a further 2% by 2011. This trend is reflected in the ongoing increase in activity levels in the maternity hospitals in the past decade and in 2004.

- **Complexity of care**
  Complexity of care is a significant contributing factor to the pressure on capacity currently being experienced by the maternity hospitals in the eastern region. Factors contributing to this increasingly complex nature of the service include the increase in first time and older mothers, higher levels of immigration, increasing numbers presenting with concomitant medical illnesses (e.g. diabetes, infectious diseases), advances in technology that enable premature babies to live from a much earlier age, and raised expectations in relation to care and outcomes.

- **Infrastructure issues**
  The three maternity hospitals have identified infrastructure layout and configuration of the buildings as a constraint to the manner in which optimal services can be delivered. The three hospitals have ageing infrastructures that were not designed to deliver the range of maternity services required today within a contemporary maternity service. They have insufficient capacity for the current and future demand for services. Current infrastructure capacity constraints are leading to unsafe, overcrowded conditions for both patients and staff and cannot be addressed without the provision of additional accommodation.
The National Health Strategy, Quality and Fairness: A Health System for You, acknowledges that models of maternity care are changing and that women are demanding greater choice with regard to the type of care they receive. It emphasises the importance of primary care and of a service that is continuous and cohesive and identifies that all future developments should be underpinned by the principles of safety, person-centredness, equity, access and accountability.

Maternity Services in the Eastern Region: A Strategy for the Future 2005-2011 identifies that future maternity services will need to be provided through a range of service initiatives and a variety of models of care, at various locations accessible to women. Within the eastern region, many advances have been made in the provision of maternity care. These developments will, however, require considerable capital and workforce investment if they are to be sustained and improved upon.

The document also identifies a requirement of service providers to work within a clear, explicit network that identifies and enhances the integration of care. This is a significant challenge to the maternity services in the region. Structures that facilitate enhancement of team working and allow for the seamless co-ordinated movement of women and/or their babies to different levels of care are required.

Implementation of the key recommendations of the strategy will

- **Increase capacity** by addressing identified current infrastructure design constraints as well as regional capital needs;
- **Further develop neonatology services** by exploring the option of a level 4 neonatal intensive care unit dedicated to the care of extremely preterm infants under 26 weeks gestation or under 750g birth weight;
- **Develop a workforce** that has the capacity to respond to increasing service needs;
- **Promote increased consumer involvement** in the planning and delivery of care.

The future developments for maternity services set out in this strategy will position maternity services to better respond to current and future demand by building on the strengths of the current system, and further developing a range of service initiatives and models of care.

In order to achieve the vision for maternity services outlined in this strategy document, implementation of the following recommendations will be required,

1. **The Health Service Executive to adopt the strategy** Maternity Services in the Eastern Region: A Strategy for the Future 2005-2011 and provide for its implementation.

2. **As current and future demands on maternity services exceed regional capacity, the capacity within the system must be improved.** This will require:
   a. A regional capital development plan to address identified current infrastructure constraints and regional capital needs;
   b. Integrated workforce planning for the delivery of maternity services by medical, midwifery and allied health staff, with particular emphasis on staffing shortages;
   c. An interdisciplinary team approach to the delivery of maternity services across all levels of care;
   d. An information and communications technology strategy to facilitate the provision of a seamless service and shared information.

3. **Increasing activity and complexity of care currently challenge the maternity services in the provision of quality care.** Enhancing the quality of care through increasing the range of services as well as models of care will require:
   a. Continued development of community-based maternity services for women with low risk pregnancies;
   b. Provision and evolution of a range of obstetric and neonatal specialised services in order to enhance care for women with medium- to high-risk pregnancies;
   c. Services to continue to be responsive to the needs of vulnerable and disadvantaged women;
   d. Development and implementation of models of care within and between primary and secondary care to increase choice and continuity of care for women;
   e. The promotion of consultation with women who use the services and their participation in planning and evaluating maternity services;
   f. A research development strategy for maternity services be developed.
Chapter 1: Introduction

The quality of maternity services determines, to a significant extent, the standard of health of the Irish population. The capacity of the three Dublin maternity hospitals to provide the highest standards of care and advice has a consequential effect on the health of the people in the eastern region and nationally.

The current and future needs of the maternity services are substantial. The former Eastern Regional Health Authority and the Joint Standing Committee of the Dublin Maternity Hospitals established a steering group in 2003 to identify current and future impact on service developments and establish a strategy for the future development of maternity services in the eastern region, based on international best practice.

To assist this process, a comprehensive assessment of women’s health needs in the context of maternity services in the eastern region was undertaken by a subcommittee of the steering group and assisted by the Department of Public Health¹.

To inform the process, The Women’s Health Council was commissioned by the former Eastern Regional Health Authority (ERHA) on behalf of the steering committee to undertake a consultation process on needs within the maternity services, focusing on the views of staff who provide maternity services and of women themselves². The Women’s Health Council conducted a literature review to identify the extent of previous research carried out in Ireland and to indicate priority areas for the consultation process. The views of women using maternity services and maternity service providers have informed the development of this strategy.

Initiatives and directions outlined in this strategy document will position maternity services in the eastern region to meet current and future demands by building on the strengths of the current services.

1.1 The Current Situation

1.1.1 Background

The eastern region comprises counties Dublin, Kildare and Wicklow. Between 1996 and 2002, the population of the region increased from 1,295,939 to 1,401,441 (an increase of 8.1%). The three Dublin maternity hospitals, The Rotunda Hospital, National Maternity Hospital and Coombe Women’s Hospital, provide obstetric, gynaecology and neonatology services for women and infants in the eastern and surrounding regions. All three maternity hospitals act as tertiary referral centres for women and babies in need of specialist treatment. Within the three hospitals, 23,204 babies were born during 2004, approximately 40% of total births in the country, and each hospital provides both public and privately funded services.

There is currently an average mix of 58% public, 19% semi-private, and 23% private activity in the three Dublin maternity hospitals, with varying percentages in each hospital. (The largest completely private maternity unit in Dublin is based in Mount Carmel Hospital, with delivery of approximately 1,400 babies per year (8% of births in the eastern region))

³ Department of Public Health (2005) Needs Assessment for Women’s Health in the Context of Maternity Services in the Eastern Region

¹ Health Service Executive Eastern Region (2006) Consultation on Maternity Services: A Board of Key Stakeholders Viewpoint Prepared by the Women’s Health Council on behalf of ERHA - Eastern Region unpublished

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1.1.2 National Context

Ireland’s National Health Strategy, Quality and Fairness: A Health System for You, was published in 2001 and is the blueprint for the long-term development of the public health system in Ireland. It identifies the goals for the health system that should guide planning and activity for a 7-10 year period.

The National Health Strategy acknowledges that models of maternity care are changing and that women are demanding greater choice with regard to the type of care they receive and the location at which they give birth. It emphasises the importance of primary care and of a service that is continuous and cohesive. It recommends increased involvement of midwives in the management and delivery of maternity services.

The entire health care system is currently being restructured in Ireland. Under the new National Hospital Office, all acute hospitals in the country, including the maternity hospitals, are grouped into hospital networks. In relation to the eastern region, there are currently three such networks with one of the maternity hospitals in each of the networks. Greater integration will be required between all acute hospitals in each of the networks and with maternity services across the networks both regionally and nationally. The stated goal of the integration of community and hospital services into one system has particular relevance for the maternity services.

Changes in society, in health care delivery and in people's expectations require changes in the approach to the delivery of maternity services so that overlap and gaps may be avoided and an integrated, high quality and consistent service is ensured.

The National Health Strategy (2001) proposes that the future development of maternity services be based on the following principles:
- Safety;
- Woman-centredness;
- Equity;
- Access;
- Accountability.

The three maternity hospitals in the eastern region provide tertiary maternity and neonatal services on a national and regional level. The hospitals also contribute significantly to the educational preparation of a range of maternity service providers, particularly obstetricians, neonatologists and midwives, and have a major role in national research development. Three of the country’s five medical schools are served by the Dublin maternity hospitals. Thus, the functions and services provided by the maternity hospitals in the eastern region have a major impact on the country’s ability to respond to the maternity needs of its population.

1.1.3 Regional Context

A comprehensive needs assessment to inform the development and planning of future maternity services within the region was undertaken with the following aims:
- To identify future maternity service requirements of the eastern region and women for whom the east has traditionally provided maternity care;
- To examine trends that will influence future capacity and activity;
- To make recommendations to address short and long term challenges.

The needs assessment revealed that in the eastern region, the population is expected to increase by 9% above the national average by 2011. On current trends, much of this increase may take place in, or in areas adjoining, the greater Dublin area. Figures for 2003 demonstrate an increase of more than 25% over a ten-year period in births to women residing in the eastern region. In 2003, 93.71% of births in the eastern region occurred within public maternity services.

In recent years, the percentage of births to teenagers has remained stable at approximately 5%, while the percentage of births to mothers aged 35 years or more has risen to 22%. Implications of this activity are reflected in the challenges presented in the following chapter.

As part of the needs assessment, a mapping exercise of hospital catchment areas and birth projections for the Dublin maternity hospitals for 2003-2011 was undertaken. Key issues identified in the needs assessment include:
- A projected increase of 7% in births between 2003 and 2011;
- The need to review the current provision of satellite clinics with view to expanding to newer suburban areas;
- Development of further community/hospital initiatives;
- More opportunities for midwife-led care;
- Staffing implications of a consultant-provided service and ensuring an adequate number of midwives in the future;
- Changes in demography;
- Need for enhanced services for vulnerable groups;
- The increasing challenge of providing neonatal care for preterm babies of less than 26 weeks gestation.

The assessment also identified and quantified current and future service demands. A significant shortage in capacity in the eastern region to meet current maternity activity and an even greater shortage in capacity for future activity was clearly identified. The main contributing factors to capacity constraints were identified as:
- Increasing activity;
- Complexity of care;
- Infrastructure issues.
Chapter 2: Regional Challenges

The projected increase in demand on maternity services until 2011, the changing demographic profile of women using the services, and the increasing complexity of service requirements as well as constraints in infrastructure layout and configuration of the three hospital buildings, are placing increasing pressure on current maternity services, and present a number of challenges to the services in the eastern region.

2.1 Increasing Activity

2.1.1 Demography and Population

The 2002 national census records that:

- Between 1996 and 2002, the population of the eastern region increased by 8% in the 6-year period. It is expected to increase by 9% more than the national average rate by 2011;
- Growth in the Dublin region varied from +0.9% in Dun laoghaire-Rathdown to +17.1% in Fingal;
- Dublin City grew by 2.9%;
- Dublin County growth was +6.1%, compared with +6% nationally;
- An increase in the population of the region has increased demand on services;
- Major increases occurred in counties adjacent to Dublin considered to be commuter counties, for example Kildare (+21.4%), Wicklow (+11.7%) and Meath (+21.1%); increases also occurred in the population of Westmeath (+13.5%), Wexford (+11.7%), Waterford (+11.1%), Louth (+10.5%) and Carlow (+10.6%);
- There are 354,827 women living in Dublin, Kildare and Wicklow between the ages of 15 and 44 and if Meath is included, this number increases to 385,881.

2.1.2 Births

- 40.2% of births were to first-time mothers in 2003.
- The percentage of births to women over the age of 35 has increased to 22%. These pregnancies are associated with higher intervention and Caesarean section rates.
- Since 1993, one third of all births are to non-married women.
- Births in Dublin maternity hospitals have increased significantly in recent years. (25% increase over the last ten years period.)
- Birth projection figures indicate that births to women in the eastern region and Meath will increase by 5% between 2003 and 2006, and in total 7% between 2003 and 2011.
- Based on migration levels continuing at 30,000 per annum, the numbers of births in this region is expected to increase from 22,908 in 2003 to 24,538 by 2011.
- Births to teenage mothers have remained fairly constant at 5%. This group have higher obstetric risk, poorer outcomes and lower breastfeeding rates.
- The average age of mothers in the eastern region was 29.1yrs in 1994, increasing gradually through the 1990s to 29.8yrs.
- As family sizes have decreased, the proportion of first time mothers as a proportion of mothers delivering in hospitals has increased from 31% in 1983 to 43.3% in 2000 (Health Information Unit, HIE - Eastern Region). Delivery time is longer for first time mothers, increasing the amount of time in delivery suites. There is also likely to be increased requirement for postnatal care and length of stay, particularly in relation to helping the new mother learn to look after her baby.
- Increasing proportions of women are having their first babies later in their lives. The number and percentage of births to mothers over the age of 35 years has increased to 22%.
- Older mothers can be associated with more problematic deliveries, higher intervention rates and higher Caesarean section rates. Previous ill health and complications of pregnancy associated with increasing maternal age and conditions such as diabetes are also increasing demands on the hospitals. Older maternal age may also be associated with existing ill health, infertility, complications of pregnancy and increased risk of adverse outcomes including stillbirths and congenital abnormalities.

The complexity of care required by women increases with the level of medical intervention during labour.

- Approximately 50% of all women in the three maternity hospitals now have an epidural during labour.
- The induction rate has increased to one in four women, an increase of 12.7% since 1997.
- Instrumental delivery accounts for 11-15% of all deliveries.
- Caesarian section rates range between 15-25%.

2.2 Complexity of Care

Complexity of care significantly contributes to the pressure on capacity currently experienced by the maternity hospitals in the eastern region. Aspects of this increasingly complex nature of the service include an increase in first time and older mothers, growing numbers presenting with concomitant medical illnesses (e.g. infectious diseases, diabetes), raised expectations in relation to care and outcomes and advances in technology that enable premature babies to live from a much earlier age.

One of the most significant changes in the child bearing pattern relates to the age at first delivery.

- The average age of mothers in the eastern region was 29.1yrs in 1994, increasing gradually through the 1990s to 29.8yrs.
- As family sizes have decreased, the proportion of first time mothers as a proportion of mothers delivering in hospitals has increased from 31% in 1983 to 43.3% in 2000 (Health Information Unit, HIE - Eastern Region). Delivery time is longer for first time mothers, increasing the amount of time in delivery suites. There is also likely to be increased requirement for postnatal care and length of stay, particularly in relation to helping the new mother learn to look after her baby.
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2.3 Infrastructure Issues

With capacity reaching a maximum, the three maternity hospitals have identified infrastructure layout and configuration of the buildings as a constraint in the manner in which optimal services can be delivered. The three hospitals have ageing infrastructures that were not designed to deliver the range of maternity services required today within a contemporary maternity service. All three hospitals have identified clinical risk management issues due to inadequate facilities and have stated that capacity constraints are leading to unsafe, overcrowded conditions for both patients and staff that, in turn, have a negative impact on the quality of service delivery. Using British formulae for calculating the number of antenatal, labour, NICU and postnatal bed requirements, the three maternity
Chapter 2: Regional Challenges

This finding presents an even greater problem in hospitals, which fall short on capacity for current activity. Capacity issues may be influenced by the further development of various models of care. However, capacity in areas such as delivery suites and NICUs will continue to sustain increasing pressures.

2.4 Medical Developments

Advances in technology have resulted in women with more complex medical problems being able to become pregnant. This has resulted in more complex maternal-fetal caseloads. Increasing demand for further antenatal screening as well as human assisted reproduction is likely to continue. The hospitals have developed antenatal care in such a way that inpatient care that was provided in the past can now be delivered as day care, for example, hypertension, fetal growth assessment, diabetes, etc.

- The incidence of Type 2 diabetes is increasing in Ireland. Approximately one in 100 women of child bearing age has pre-existing diabetes, while between 2-12% of women develop gestational diabetes.

- Maternal mortality rates amongst babies of diabetic mothers can be up to 5 times higher than in the general population.

2.5 Neonatology

The development of neonatology services is closely linked with maternity services. Higher survival rates of premature babies and babies of low birth weight requiring complex care are placing higher demands on neonatal units. Technology has enabled premature babies to live from a much earlier age (24-26 weeks) and this increases the demand for neonatal care.

- Internationally in consultant-led obstetric units, 20-25% of deliveries are attended by members of a neonatal team.
- 10% of all babies delivered require paediatric intensive care.
- Preterm births account for 75% of neonatal handicap.

Neonatal care is currently delivered at three levels. Level 1 is care of the healthy term newborn. Level 2 is the care of infants with low birth weights of 2.0-2.5kg and the care of term infants with minor problems, and Level 3 is the tertiary care of critically ill infants. With the increased survival rates of very premature babies, care is now required at Level 4 for the most fragile, extremely preterm infants under 26 weeks gestation or under 750g birth weight. This new level of care is placing increasing pressure on service delivery in neonatology and requires further development and resources.

2.6 Litigation

Ireland has the second highest litigation rate after the United States, and this is an issue of concern for service provision and outcome. The high rate of litigation in Ireland has had an impact on the provision and outcomes of maternity services. International evidence suggests that provision of care is based around increasing avoiding litigation, generally through early intervention. The introduction of Enterprise Liability by the State may have implications for the provision of maternity care in private hospitals.

2.7 Expectations

Access to information has significantly increased the expectations of women in terms of access to and choice of services, and participation in decision-making. Women are generally well informed of the range of services available and increasingly exercise the right to be involved in decision-making about how and where they would like to deliver.

There has been a significant shift in the view of maternity service users from patients of a service who receive services provided to that of consumers of a service who have input into the type and quality of service available.

Through the consultation process conducted by The Women’s Health Council, Ireland, with service users, women revealed that their requirements of a maternity service were:

- A good outcome; that is, a safe delivery with no negative consequences for mother or baby;
- Continuity of care;
- Support and reassurance;
- To be treated as an individual.

It was apparent through the consultation process that service providers are concerned about the high level of pressure created by the current level of activity in the hospitals and the consequences for service users. Women who had babies previously commented on the lower levels of service they experienced in the last year compared to three to five years ago. The pressure on staff has resulted in less than optimal time for individual women and their needs. This, together with the lack of continuity of staff in the care of women and the lack of full information available to women to make an informed choice regarding their care, are key issues to be addressed. In addition, due to various vulnerabilities or social circumstances, some population groups have significant difficulties with the services.

2.8 Social Inclusion

Tackling social inclusion and health inequalities is a challenge for the whole health service. Social groups in the lower socio-economic areas are known to have poorer maternity outcomes for both mother and infant. Enhanced services are needed for such groups and, in particular, for drug misusers, marginalised and deprived communities, homeless people, ethnic minorities and those with mental health difficulties. A higher awareness of additional services required by women with complex social, physical and mental health needs has developed amongst service providers.

2.9 Immigration

Corresponding to increased levels of immigration to Ireland in recent years, one in four births within the eastern region in 2003 were to women born outside of Ireland. Cultural differences in expectations relating to care, communication difficulties due to language differences, social needs relating to housing and lack of supports available to many new arrivals place increased pressure on hospitals to respond to the needs of individual women. Women presenting late in pregnancy without antenatal records and with concomitant medical illnesses place further pressure on services.
2.10 Workforce

- European and national policies on medical and midwifery staffing levels, and staff shortages in particular areas, add to the pressures on maternity services in the eastern region.
- The imposition of the employment ceiling constraints across the maternity services has presented a challenge for hospitals in implementing agreed service developments. The timely implementation of any approved additional services will continue to present a challenge while continuing to operate within tight employment constraints in future years. The key factors that have driven the need for additional staffing within the maternity hospitals sector include: increased activity, staffing requirements associated with approved service developments, clinical risk management demands, health and safety concerns and legislative compliance requirements. It has been acknowledged that the increased reliance on agency nursing, overtime and other forms of outsourcing in order to contain employment numbers is not satisfactory from an overall value for money perspective. There are challenges in striving to maximise value for money, and continuity and quality of care while operating within employment ceiling constraints.

2.11 Related Activity

In line with the increase in activity in the maternity hospitals, related care services have also experienced an increase in activity. A profile of increasing activity in key care areas in the National Maternity Hospital in the last ten years and similar activity in the two other maternity hospitals is as follows:
- Theatre activity: 60.6% increase;
- Emergency room attendances: 32.7% increase;
- Outpatient activity: 23.4% increase;
- Fetal assessment activity: 27.2% increase;
- Laboratory activity: 48.3% increase;
- Length of stay of patients: the decrease in length of illness from 1999 to 2003: 13.4% decrease.

Maternity services within the eastern region will continue to provide safe care to women in all phases of pregnancy and childbirth while offering increased choice, equity, participation in decision-making, and continuity of care.

This vision for maternity services is based on the principles of safety, woman-centredness, equity, access and accountability, which guide and inform the developments in maternity services as set out in this strategy document.

Maternity services require the resources and flexibility to meet the individual needs of all women and their babies with due concern for the medical safety of options offered. All future developments of maternity services will reflect clearly each of the following principles.

3.1 Safety

To ensure the safety and quality of health care services, care should be evidence-based and meet approved standards determined by an interdisciplinary team in partnership with consumers. A quality service requires processes to enable continuous evaluation of the service and external validation of standards to enable continuous monitoring and improvement of service delivery.

The development and application of risk assessment tools and risk management practices will contribute to the improvement of the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents.

When making choices about maternity services, women should have sufficient information about the range of services available to make informed decisions and choices, and information about the risks, benefits and indications for those choices. Information must be available in a variety of formats and languages to ensure that all women have access to information required for informed decision-making and participation in care.

Obstetric and midwifery protocols, standards and criteria, informed by evidence-based research, should be standardised across all services and guide decision-making in relation to care provided to women.

3.2 Woman-centredness

Woman-centredness reflects the principle of ‘people-centred’ of the 2001 National Health Strategy, Quality and Fairness. “The people-centred’ health-care system of the future will have dynamic, integrated structures that can adapt to the diverse and changing health needs of society generally and of individuals within it. These structures will empower people to be active participants in decisions relating to their own health”4. A limitation of the current system identified by the National Health Strategy is that patients and clients often have to adapt to the way the health system works, rather than the system responding to their needs.

The National Health Strategy (2001) suggests that “for a service to be people-centred:
- Services must be organised, located and accessed in a way that takes greater account of the needs and preferences of the community they serve;
- Health and social systems must be able to accommodate differences in patient preference and encourage shared decision-making;
- Consumers are given greater control, but also greater responsibility for their own health,”

5. Ibid, p38

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• Consumers need access to high-quality information on health to fully benefit from health and social systems and to participate in decisions relating to their health. Readily available information stimulates self-help and informed choice;

• Increased involvement of consumers as partners in planning and evaluation is an important component in promoting openness and accountability**.

Clearly, women accessing maternity services have differing needs and preferences, and a modern maternity service needs to be able to recognise and meet such differing needs. Women must be at the centre of an integrated maternity service that provides choice, encourages consumer participation in care decisions, and achieves high levels of satisfaction. Evidence-based information and advice must be accessible and available to women to facilitate their full participation in decision-making regarding where and how they give birth.

The planning and monitoring of services should be informed by the needs of women. It should ensure that explicit policies and practices are in place to empower women individually as full partners in their care. Central to the future development of maternity services should be a woman’s right to privacy and dignity.

3.3 Equity

“Equity is concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible”.

Equity is to be central to the development of maternity services in the eastern region to ensure equal access to maternity services for all women within the region based on need. The development of maternity services must respond to the diversity amongst women that may influence their ability to access services and potentially contribute to unequal opportunities for health and differing health outcomes.

Differences based on social, economic, cultural, physical, mental health, or demographic factors should not influence the availability of information for women on maternity services, or the availability or provision of services.

The needs of some groups of vulnerable women such as homeless women, drug misusers, women who experience violence and teenagers, amongst others, are not always fully met by current maternity services. Future service development should focus on the needs of these women to ensure that they have equal access to services.

Equity and accessibility must be features of a modern maternity service, that is, equitable access to such services as ultrasound examination and antenatal screening and counselling services must be ensured.

3.4 Access

To achieve desired health outcomes, accessible and culturally appropriate information and services must be available to all women.

Underpinning the development of maternity services is the objective of providing flexible, responsive, quality, accessible services in response to the needs of women. This entails ensuring that services for women and their families encompass the cultural values, beliefs, attitudes, ethnic backgrounds and lifestyles of users of the service.

In ensuring that services are accessible to all women, services must be responsive to women with special needs, such as physical and learning disabilities and mental health problems, and provide appropriate access to the full range of maternity services. Furthermore, services need to be responsive to the needs of women of culturally and linguistically diverse backgrounds, teenage and young women, and women at psycho-social disadvantage. That is, maternity services must be culturally sensitive in the broadest and most encompassing sense.

The accessibility of services for women will be determined also by the location of services. Services that are close to where women live or work, accessible by public transport, and that provide sufficient parking, enhance accessibility. The timing of the delivery of services will also influence accessibility and should reflect as much as possible the lifestyles of women in 2005-2011.

3.5 Accountability

The National Health Strategy (2001) emphasises that “Accountability means financial, organisational and professional responsibility is strengthened for better quality, efficiency and effectiveness” and stresses the importance that “Planning and evaluation models must demonstrate that available resources are used as efficiently and effectively as possible”.

The HSE has developed a multifaceted approach to deliver value for money within all healthcare services, including maternity services in the east. However, providing cost-effective care goes beyond cost-minimisation strategies and requires a comprehensive analysis of how the health system functions as an integrated system and how resources are used against a backdrop of medical inflation, managed care, medical technology and health policy.

Quality and continuous improvement measures must be inherent in the development of maternity services and focus on both processes and outcomes. The efficacy and effectiveness of maternity services may be demonstrated by adherence to agreed clinical standards and key performance indicators.

Mechanisms for the collection of data on the performance of maternity services will require further development and standardisation of information technology in and between hospitals. Performance measurement, evidence of consumer consultation and the use of evidence-based information in the planning, delivery and monitoring of services will strengthen accountability to both government and consumers.

The future development of maternity services that meet the needs of individual women would be best informed through the establishment of liaison committees that include consumer representation.
Chapter 4: Enhancing Quality
In Future Service Delivery

During 2004, 23,204 births occurred in Dublin’s maternity hospitals. The quality of the care provided to these babies and their mothers will have a long-term impact on the future health of the population. The Health Service Executive (HSE), together with the providers of care, is committed to maintaining the high standard of safety currently provided within the maternity services. There is also commitment to increasing service options for women in line with international best practice and consumer expectations. Facilitating choice and promoting a woman’s participation in her care will enhance the quality of services, as well as facilitating those women with specific needs such as women challenged with disability or drug misuse.

Issues identified by the consultation process as requiring radical change in order to enhance quality in service delivery were:

- The lack of information given to women;
- The lack of opportunity to discuss services provided;
- Overcrowding in the hospital outpatient departments.

Reduction in the size of antenatal clinics can be achieved with increased input from primary and community-based health services with ready access to hospital expertise and to the availability of ultrasound and consultant input when required.

Enhancing the quality of service delivery must ensure that no group of women experiences discrimination.

This chapter highlights key issues to be addressed in the future delivery of quality maternity services throughout the region.

4.1 Service Initiatives

4.1.1 Preconception and Early Pregnancy

Health promotion activities focusing on the education of women regarding their own well-being and that of their babies should be vigorously undertaken and maintained. Activities should be aimed at:

- Highlighting the positive effects of folic acid and encouraging an increase in folic acid uptake amongst women prior to conception;
- Minimising the intake of alcohol by pregnant women;
- Ensuring rubella immunity prior to pregnancy;
- Reducing rates of smoking amongst pregnant women and mothers;
- Reducing the use of recreational drugs in the community;
- Promoting the general health and mental health well-being of women.

Most women of childbearing age are healthy individuals, therefore their main contact with the medical services prior to pregnancy may be during family planning consultations with their general practitioner (GP). As approximately half of all pregnancies are unplanned, these visits should be used as opportunities by the GP to discuss pre-conceptual health.

Discussion is required at national level around the mandatory fortification of food with folic acid. Some prospective parents require specialist preconception advice. These include women with conditions such as epilepsy, schizophrenia, bipolar affective disorder, diabetes, or heart disease who are receiving treatment by medication that may have adverse effects on the health of an unborn baby. Prospective or existing parents with a family history of a genetic disorder and those concerned about familial disease or disability also may require specialist preconception advice.

Couples experiencing infertility problems or threatened miscarriage may present to their GP for initial consultation and investigation. Agreed shared protocols are recommended between maternity hospitals and GPs to avoid unnecessary duplication of investigative procedures during what can be a difficult time for the women concerned.

4.1.2 Antenatal Services

Antenatal care should maximise positive clinical outcomes as well as provide support and reassurance. The work of obstetricians, GPs and midwives is fundamental to high quality antenatal care and the HSE seeks to enhance these roles. For example, the further development and enhancement of the role of the midwife in the community will offer choice and availability to healthy women experiencing low-risk pregnancy. Continuing role developments will contribute to more focused, woman-centred maternity services that are delivered in partnership by all health care providers who comprise the maternity team.

The quality of antenatal care is influenced by the quality and amount of information and support provided to women to enable them to make informed choices about their maternity care. Some women however, particularly those from more vulnerable and disadvantaged groups, may require additional support as well as access to social workers. The consultative process identified that women want more information than is currently provided to them.

Antenatal Screening

Women require information in a manner that suits their needs. This is particularly relevant in the case of antenatal screening tests. Developments in antenatal screening technology allow the early detection of complications and abnormalities in pregnancy. Despite this, access for women in Ireland to antenatal screening for detection of fetal abnormality is limited. Furthermore, in the absence of national policy, access to diagnosis is limited and presents many ethical and physical challenges to women and service providers. Review of the availability of screening procedures and counselling services is required. Every woman should have an opportunity to have a detailed fetal anomaly scan during their pregnancy. Women should be informed of international best practice in screening for fetal anomaly.

Specialist Clinics

The increasing incidence of a number of social and medical conditions amongst pregnant women in the eastern region requires the specialist knowledge of service providers to minimise or prevent complications for women and their babies. Maternity care providers working in both primary and secondary care should be competent in recognising, advising and referring within agreed protocols women who would benefit from more specialist services. The application of risk assessment tools for the early identification of a range of potential complications during pregnancy may enhance the opportunity for early intervention and improve outcomes for mother and baby.
Medical advances and the fact that women with more complex medical problems are becoming pregnant have resulted in newer and more complex care. Local and international experience demonstrates that outcomes for pregnant women with complex social and physical needs can be improved if appropriate support, monitoring and specialist care is available. Specialist clinics provide a streamlined, co-ordinated service to women and their babies throughout the antenatal period, labour, birth and postnatal period. Specialist clinics provide a centre for liaison with other services, support the delivery of integrated care, provide a centre for developing expertise, and support research and best practice. Examples of areas of medical specialties include:

- Diabetes;
- Infectious diseases;
- Respiratory;
- Cardiology;
- Haematology;
- Neurology;
- Psychiatry.

Currently, each Dublin maternity hospital provides varying degrees of tertiary specialist services. These services have evolved out of need but with increasing numbers of women requiring specialist care, the HSE must address the strategic planning of such services. Identified specialist clinics to deal with maternal illness in pregnancy need to be further developed within the region. Formal links with acute general hospitals, particularly within identified hospital networks, need to be further enhanced to facilitate an integrated approach to service delivery that places the woman at the centre of care.

**Early pregnancy clinics**

Up to 20% of pregnancies result in miscarriage and 1% result in an ectopic pregnancy. Early pregnancy clinics should be available in each of the hospitals to facilitate rapid assessment. Facilities should include at a minimum, high quality ultrasound facilities to check pregnancy viability, gestational age and that the pregnancy is intrauterine. The unit should provide a suitable environment for worried or distressed mothers and their partners. Staff working in these clinics should have suitable expertise and be trained in counselling.

**Parent education**

In ensuring that all women have access to appropriate, evidence-based information relating to maternity care services and parenthood, the quality and content of parent education sessions should be regularly reviewed and evaluated. Parent education should be offered to communities at easily accessible locations and times, and be responsive to the needs of women from culturally and linguistically diverse backgrounds.

### 4.1.3 Women with Additional Needs

All women should have easy access to and confidence in the full range of high quality services which are available. However, there are women who do not use or fully use maternity services and are often from disadvantaged groups e.g. homeless women, women with intellectual disabilities, drug users, asylum seekers, HIV positive women, women with mental illness, and teenage mothers. Regional services should be developed to take cognisance of these women's situations.

**Mental health**

All maternity service providers should have agreed policies and protocols for identifying and supporting women at high risk of developing a serious postpartum mental illness. Early intervention for women who are at risk of developing postnatal depression may be facilitated by the development of a strategy for risk assessment and management. Several studies reveal that there is a 10-15% prevalence of postnatal depression. Adverse effects on the baby may include insecure attachment and cognitive development deficits. Services should be developed to promote mental health risk assessment during the antenatal period. Follow up services for postnatal depression, developing mental health specialist teams within maternity services, mental health education of all staff providing maternity care, and the provision of community and residential mental health supports for mothers and their babies during the postnatal period should be prioritised. A mother and baby unit should be available within the acute sector.

**Domestic violence**

Research in recent years has highlighted the increased risk of domestic violence for women during pregnancy with almost one third of domestic violence beginning during pregnancy. Domestic violence is associated with increased rates of miscarriage, premature birth, low birth weight, chorioamnionitis, fetal injury and fetal death. Violence can cause life threatening complications and even result in the death of the mother and/or her child.

Increased awareness of domestic violence, improved identification techniques, education on available social and legal interventions, as well as liaison between relevant agencies is required. Early identification of women at risk of domestic violence is possible during the antenatal period through staff education and the development and use of a risk assessment tool. All maternity care providers should be aware of the significance of domestic violence in their practice and be competent in recognising the symptoms and presentations. If concerned, they should be able to make sensitive enquires and provide basic information about or referral to appropriate services as required.

**Cultural and linguistic diversity**

The increasing cultural and linguistic diversity of women seeking maternity services in the eastern region has highlighted the importance of education on cultural awareness amongst service providers. Women seeking maternity services in the eastern region are from a variety of ethnic and cultural backgrounds with differing beliefs and norms concerning pregnancy, parenting and the roles of women, men and children. Providing for differences in cultural beliefs and attitudes amongst women in order to provide individualised care to women can present many challenges to service providers. Staff education on cultural difference, individualised care plans that reflect cultural beliefs and requirements of women and liaison with community groups to inform service development contribute to appropriate service development and improved satisfaction levels amongst women.

### 4.1.4 Intrapartum Services

Decisions regarding where a woman gives birth will normally be decided in advance by the model of care she has chosen. Models of care are described in section 4.2. Women's birth experiences can influence their emotional wellbeing, their relationship with their baby and their future parenting. Continuity of care from the same midwife during labour, adequate information and explanation of the progress of labour, choice of pain relief and health professionals supporting a
nurses. Family support coordinators have been care providers i.e. midwives, GPs and public health through the network of community-based maternity ensure seamless continuity of care made available following hospital discharge. These supports should are in place for all women in the early days there is a need to ensure that professional supports DOMINO and early transfer home programmes, to postnatal discharge. With the introduction of mothers are often not identified or reported prior Studies have shown that health problems of new services to the needs of women. The establishment of step down facilities from maternity hospitals, for women with special needs requiring ongoing non-acute care prior to discharge, provides additional support for women and reduces their length of stay as inpatients in acute maternity services.

Studies have shown that health problems of new mothers are often not identified or reported prior to postnatal discharge. With the introduction of DOMINO and early transfer home programmes, there is a need to ensure that professional supports are in place for all women in the early days following hospital discharge. These supports should ensure seamless continuity of care made available through the network of community-based maternity care providers i.e. midwives, GPs and public health nurses. Family support coordinators have been identified by medical social workers as an important support service and their availability should be increased.

4.1.5 Postnatal and Neonatal Services

Postnatal support for women

The length of the postnatal hospital stay for women can be shortened through the development of comprehensive postnatal supports provided in the community by hospitals and integrated with community services. Partnerships between hospitals and community services to plan and provide flexible, postnatal support, in particular targeting those in marginalised and deprived communities, ethnic minorities, homeless people and those with mental health difficulties, improve the responsiveness of services to the needs of women. The establishment of step down facilities from maternity hospitals, for women with special needs requiring ongoing non-acute care prior to discharge, provides additional support for women and reduces their length of stay as inpatients in acute maternity services.

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Neonatal services

The needs assessment report identified the need to expand existing neonatal services in the eastern region to respond to the increasing pressure on current neonatal services due to the increase in babies born prematurely. Services responding to perinatal and neonatal emergencies must be integrated with maternity services. The highest level of care must be available and accessible for the needs of new-born babies and their parents. A national neonatal transport system should be available 24 hours each day to respond to perinatal and neonatal emergencies, with appropriate protocols and guidelines for emergency referral. A national plan for the development of neonatal paediatric services is required. The increased use of prenatal diagnosis will increase the number of referrals to the three maternity hospitals in Dublin. The establishment of close links between the maternity and paediatric hospitals in the region and nationally will be essential to the provision of a seamless service. This is particularly true for women whose babies will ultimately require paediatric surgery.

The integration of neonatal tertiary and community services provides continuity of care, contributes to shorter hospital stays and provides comprehensive follow up care for newborn babies. Clear guidelines for post-discharge care tailored to the needs of the baby that accompany each baby on discharge and referral pathways to community services are necessary to support ongoing continuity of care.

Breastfeeding

The benefits of breastfeeding to both mother and baby have long been established internationally. Figures show that only 37% of mothers in Ireland commence breastfeeding. Breast feeding initiation rates are higher in the eastern region at 40.5%.

Health promotional activities to raise awareness of the positive benefits of breastfeeding and to increase the rate of breastfeeding amongst recent mothers in the eastern region can be achieved through collaborative efforts of maternity hospitals and community health services. Timely, consistent information that reflects best practices is needed. Structured supports and services for mothers and health professionals in both hospital and the community will promote, support and sustain higher breastfeeding levels among recent mothers.

4.2 Models of Care

The 2001 National Health Strategy, Quality and Fairness, notes that models of maternity care are changing, with increasing demand for choice with regard to type of care and location of birth. It emphasises primary care and reinforces the need for a comprehensive approach to maternity care so as to ensure continuity and choice for women. The strategy recommends the increased involvement of midwives in the management and delivery of maternity services and an increased choice of care givers for women. Future maternity services should increase options for women and ensure that evidence-based information on the benefits and risks associated with the different options is available to all women.

4.2.1 Levels of Care

Women may require maternity services at either one or more levels of care:

- Primary;
- Secondary;
- Tertiary.

The care provided across these levels should be continuous and integrated extending through pregnancy, labour, birth and the postnatal period.

Primary maternity services should be made accessible to all women experiencing uncomplicated pregnancies. Generally, a woman experiencing an uncomplicated pregnancy does not require ongoing specialist supervision and this is recognised within primary maternity services.

The HSE acknowledges this and will enhance primary maternity care throughout the region. The three maternity hospitals currently provide a combination of community-based obstetric and/or midwifery led care in partnership with GPs. The wider provision of community-based services by midwives and general practitioners will ensure that women have access to services and information within an appropriate geographical location and save them from having to travel to busy, hospital-based antenatal clinics. These developments will lessen the antenatal demand on maternity hospitals in central Dublin for ‘low risk’ women and enable the hospitals to focus on the provision of obstetric care for women who are ‘at risk’ or have complicated pregnancies.

Resulting from the needs assessment mapping exercise, the need for further expansion of outreach antenatal clinics in the north of the city was identified.

The role of the GP in the provision of the Mother and Infant Care Scheme (combined antenatal care) should continue to be promoted by the hospitals. A national review of this scheme is required to allow it to meet the changing needs of women. The Needs Assessment identified considerable scope to increase the uptake of this scheme in the eastern region.
Chapter 4: Enhancing Quality In Future Service Delivery

Women will be referred as needed to secondary or tertiary level services (or service providers) that provide a higher level of medical care.

Secondary maternity services meet the needs of women who develop complications and require transfer or referral to specialist medical care. This level of care is targeted at women who experience moderate complications. Transfer or referral to specialist levels of care should be available to all women who require it for complications arising during pregnancy, birth or the postnatal period.

These women are not at the highest risk, but require medical input from specialists in partnership with hospital-based midwives. This integrated approach, between primary and secondary care providers, to caring for the pregnant women with additional needs will be facilitated by the use of agreed shared criteria, protocols and referral pathways.

Tertiary maternity services provided by specialist obstetricians are available for women with complex or high-risk pregnancies who require specialist care and monitoring of mother and baby. Interdisciplinary specialist care may also be required at this level. The three Dublin maternity hospitals are tertiary referral units.

Notwithstanding, a tertiary maternity hospital may be the most local and convenient location for the care of women with low-risk pregnancies and will continue to provide appropriate care to these women.

The devolution of services from the model in which acute hospital maternity units provide all services, to models in which the services are available in accessible locations, provided by the most appropriate care deliverers and with increased participation by the women involved, has begun and is recommended in this strategy. The Needs Assessment and the consultation process with service users and providers that were undertaken and which inform this document would indicate that a number of models of care should be developed further.

It must also be acknowledged that there are times when women will need to be transferred to tertiary services in emergency situations. In all circumstances, adherence to referral guidelines is required to ensure safe and effective care.

4.2.2 Continuity of Care

Continuity of care refers to the integrated, seamless pathway of care provided to a woman throughout all stages of pregnancy, labour, birth and post delivery, including referral to child health services. There are various models of care that provide continuity of care that will continue to be developed within the eastern region over the next six years:

1. Shared Care - Care is shared between two health professionals, which in most cases is a midwife/obstetrician and a GP.
2. Consultant Obstetric Care - Women choose to attend the obstetrician and hospital midwives for all their care;
3. Team Midwifery - A small team of midwives cares for the woman.

All models of care within the public hospital system are supported by a consultant obstetrician. The consultative process identified a need to increase choice, extend the current community-based schemes (Early Discharge Home and DOMINO) and ensure that women are aware of options available to them. Information available to women to make choices about models of care they select from should be evidence-based, easily accessible and in appropriate formats for all women.

Continuity of care for women will be enhanced through the development of partnerships between hospitals and community. Continuity of care may be provided to women as they can and do move between consultant and midwifery-led services.

Models of care will operate between ‘low risk’ and ‘high risk’ working to the same vision and philosophy of quality and care.

4.2.3 Integration of Care

Each model of care requires shared criteria and protocols, referral pathways and communication channels that are transferable across all models. Further development of a maternity service that operates in a defined service framework will achieve the balance between choice and access. This approach will make the best use of the complementary skills of midwives, GPs and obstetricians, while promoting interdisciplinary learning, respect and trust among these different disciplines. This approach will assist women to move seamlessly through the different levels of care.

The development of models of care should be evidence-based and culturally appropriate to ensure available access to women. Future maternity services should provide women with the opportunity to choose a lead professional appropriate for the level of care she requires. Should a woman require different levels of care throughout her pregnancy, labour, birth and postnatal period, guidelines and referral arrangements should be in place to support the transition within an integrated maternity service. Further development and standardisation of information technology in and between services within the eastern region and within an identified hospital network is required to support the full integration of services. Lack of access to shared databases was raised as a problem by service providers in the consultation process.

One client-held medical record that incorporates all the information required for each service provider would facilitate integration and communication within the service.

The development of standards of care for maternity services consistent across all models, locations and providers within the eastern region would remove serious variability between services and service providers. Furthermore, agreed criteria and pathways for referral across models of care and between care providers, and referral to required services, will contribute to the development of a seamless, integrated maternity service that provides continuity of care.

4.3 Research and Development

The culture of medical research within the three hospitals is well established and recognised internationally. Numerous papers are produced and published yearly by staff within the hospitals. In recent years, a number of collaborative research projects between the three hospitals have been undertaken. The combined efforts of the three maternity hospitals in the area of clinical and basic science research has the potential to significantly advance our knowledge in the area of maternity care and is very likely to continue to influence clinical practice.

The appointment of a joint Clinical Research Fellow between the maternity hospitals and the Mater Hospital Endocrinology Department is one such recent collaborative initiative. Increased liaison with the Department of Public Health and Epidemiology Unit of each of the medical schools...
Chapter 4: Enhancing Quality In Future Service Delivery

The number and complexity of women and babies receiving maternity services provides an ideal opportunity for audit, evaluation and research by all professions.

The contribution maternity hospitals can make to research and subsequent improvements in outcomes and quality of care must be supported through future research development. The information technologies, library and other facilities that are required to support audit and research need to be well developed. The further development of links between maternity hospitals and academic centres will go someway in supporting evidence-based practice, new models of care and service delivery and research development.

The gap between research, evaluation and practice may be decreased through improved communication of research findings to inform continuous service improvement. Each of the maternity hospitals is linked with third level education providers for the clinical placement of medical, midwifery and allied health students. The development of collaborative research partnerships between maternity services and academic centres will broaden the scope of research, coordinate research activities and inform practice, policy and planning. The evaluation of services and outcomes of service delivery will inform service development.

Midwifery and nursing research has been developing over recent years leading to an increase in research skills within the professions as well as increasing the capacity to utilise research findings in the practice setting. A strategy for nursing and midwifery2 was developed by the Department of Health and Children in 2003 and provides a framework for the development and growth of nursing and midwifery research in the future. Enhancing the work of the strategy further, as part of an European Union initiative, the Health Research Board is currently taking the lead in Ireland on a project to identify existing national and regional programmes of nursing and midwifery research throughout Europe, identify clear opportunities for collaboration and networking and to share ideas and build a strong evidence-base for nursing and midwifery practice.

It is essential that the separate and autonomous nature of the profession of midwifery is recognised. It must attract and acquire all the academic credibility, comparable funding, and research and development opportunities as exist for other professions. Consideration should be given to the clinical appointment of a Professor of Midwifery who would provide leadership in midwifery research.

A research-based culture in the practice, education and management within maternity services should be developed and maintained. Interdisciplinary research should be supported and promoted within and between services.

4.4 Governance

Clear structures of governance should exist within services to provide necessary transparent and accountable structures for the development and monitoring of financial and clinical quality management.

Corporate governance has been defined as a system by which organisations are directed and accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish18. All disciplines involved in providing patient care have a significant role in clinical governance.

Key elements of clinical governance include:

- Clinical effectiveness;
- Clinical audit;
- Professional self-regulation;
- Lifelong learning;
- Revalidation;
- Clinical risk management;
- Policies, procedures and protocols;
- Partnerships in practice;
- Information technology;
- Ethics.

Clinical governance has a number of features:

- Patient centred care - this means that patients are kept well informed and are given the opportunity to participate in their care;
- Good information about the quality of services is available to those providing the services as well as to the patients and the public;
- Variations in the process, outcomes and access to healthcare are greatly reduced;
- Risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the service.19

Through interdisciplinary collaboration, maternity services will develop comprehensive structures and processes that support each element of clinical governance. Within services, clear lines of responsibility and accountability for the overall quality of clinical care, a comprehensive programme of quality improvement activities and clear policies aimed at managing risks should be developed.

Quality management systems that ensure continuous evaluation and improvement of service delivery and outcomes should become an integral part in future service development. Interdisciplinary teams will be responsible for collaboratively providing the highest quality of service and to involve service users in the design, delivery and evaluation of services.
Chapter 5: Future Capacity Requirements

Collectively, activity within the three Dublin maternity hospitals, The Rotunda Hospital, National Maternity Hospital, and Coombe Women’s Hospital, is exceeding the capacity of the existing regional infrastructure. This is mainly due to increasing activity and complexity of service need as well as existing infrastructure constraints. Improved capacity within the system is required to deliver quality care and is dependant on the following issues:

• Capital development;
• Workforce planning and development;
• Information and communications technology.

5.1 Capital Development

The main infrastructure challenges at the Dublin maternity hospitals are that:

• All three hospitals have ageing infrastructures that were not designed to deliver the current range of services required by a contemporary maternity service;
• When combined, they have insufficient capacity for the current and future demand for services in the region, increasing the potential risk of unsafe, overcrowded conditions for both patients and staff;
• All three hospitals that are tertiary referral centres are located in Dublin city centre.

5.1.1 General Capital Requirements

The Needs Assessment has demonstrated that the three maternity hospitals will continue to experience increasing service pressures. The hospitals have insufficient capacity to meet the growing demand on services without the provision of additional accommodation, beyond that which is already approved. In planning future developments for the provision of antenatal and postnatal beds, delivery suite beds, neonatal cots, outpatient clinic and laboratory services, capacity must reflect the current and future demands on this service. Within the three Dublin maternity hospitals capacity requirements also include appropriate facilities and resources for education, research and training requirements.

Based on international best practice and local conditions, the British NHS applies a formula to estimate requirements for the number of antenatal, labour and postnatal beds. This formula takes into account the number of births, staffing levels and service practices. Applying this formula to the Irish setting, the three maternity hospitals fall short on capacity for current activity in relation to antenatal beds by 17%, postnatal beds by 12% and delivery suites by 35%. When future requirements are considered, taking account of the increased number of births and planned capital developments, the capacity shortfall is still substantial. Capacity within the three hospitals will fall short of projected need in 2011 by between 9% and 22% for these types of beds or delivery suites.

For the majority of women, pregnancy and childbirth are normal life events requiring minimal medical intervention. These women may choose to have community-based midwifery led services that are easy to access and offer continuity of care. Current capacity within the community should facilitate the further development of these services. With an increased availability of such services, capacity pressures in certain hospital departments such as antenatal clinics should be reduced.

However, while capacity issues may be influenced and ameliorated somewhat by the further development of various models of care in the community (which in turn will be influenced by staff and funding availability), they will not substitute for infrastructure developments within the three hospitals as the vast majority of births will continue to be hospital-based deliveries.

Another important infrastructure challenge to the maternity services in the eastern region is the structural layout of the hospitals. Regardless of increasing activity, the three maternity hospitals will also be required to alter current structural layout in order to provide a safe service in a conducive environment supported by all appropriate facilities and according to international standards. Older hospital buildings tend to create impersonal, institutional atmospheres and are unsuitable for the needs of a contemporary maternity service.

5.1.2 Neonatal Capital Requirements

Advances in technology that improve survival rates for babies born in early gestation (under 26 weeks) are likely to increase pressure on neonatal intensive care services. Currently, newborn care is divided into four levels of care areas must be increased.

A summary of the key capital requirements based on international best practice is provided in the following table. This table illustrates the current capacity, the current deficit and projected future capital deficit in the area of maternity services.

The UK Clinical Standards Advisory Group in its report on Neonatal Intensive Care (1993) advise that neonatal cot needs range between 0.4 and 1.5 intensive care cots per 1,000 births and 4.5 special care cots per 1,000 births. In Northern Ireland, the Royal Group of hospitals while undertaking a rationalisation of maternity services, estimated that 7,000 births would require 43 neonatal cots in the neonatal unit based on an occupancy rate of 75%. As the Dublin maternity hospitals are tertiary referral hospitals, the need for intensive care cots is at the upper limit of this range. Using this formula based on both current and projected future activity, the three hospitals have identified a need for increased Neonatal Intensive Care Unit (NICU) cots and staffing. Current NICU bed capacity deficit is calculated to be 37%. Acknowledging planned capital developments in NICU, the shortfall of beds for projected births for 2011 will be 35%. This highlights that capacity in the neonatal intensive care areas must be increased.
Chapter 5: Future Capacity Requirements

Through an alternative proposal for the enhancement of integrated hospital care is to further develop closer perspectives and in relation to access to specialised services and technology will be available. Consequently, the national concentration of Level 3 care to a small number of units and Level 4 care to one or two units must be the goal. Level 4 care could be concentrated in one of the three Dublin maternity hospitals. Due to the high birth rate in the three Dublin maternity hospitals and their role as tertiary referral centres, all three hospitals should continue to provide Level 3 care and ideally in the future all three hospitals would also provide selected minor cardiology and surgical procedures on site.

In addressing the issue of the location of future capacity, priority must be given to current infrastructure deficits that have clinical risk implications. This is particularly relevant to National Maternity Hospital (NMH) where approved proposals for interim infrastructure developments to address this issue should be implemented. However, the site of NMH is a constraint on future service development and therefore in the longer term the hospital should be relocated to an acute hospital site to allow for increased capacity if required. This relocation would also improve access for the catchment population both from a geographic perspective and in relation to access to specialised acute services.

Table 1: Combined capacity for the three maternity hospitals including estimates of current and future capital deficit

<table>
<thead>
<tr>
<th>No. births</th>
<th>Number of beds</th>
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<tbody>
<tr>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td>23,204</td>
<td>95</td>
</tr>
<tr>
<td>16</td>
<td>38</td>
</tr>
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The above table shows that by 2011, it is estimated that the capital deficit for maternity services will range from 9% to 32% depending on the type of service required.

5.1.3 Location

There has been considerable debate regarding the ideal location of maternity services. The National Task Force on Medical Staffing report has recommended that in the ideal situation, the acute in-patient service of single speciality hospitals should be moved to the site of a major hospital. This should enable faster access to onsite specialist support, increase efficiencies in staffing and reduce duplication of staff and support services. The Hanly report has specifically singled out the National Maternity Hospital as moving in the long term to St. Vincent’s site. While acknowledging the principles of the Hanly report, it is important to note that maternal mortality rates within the Dublin maternity hospitals are among the lowest in the world, and significant capital costs/service logistics would be incurred in moving all maternity hospitals in the region to acute hospital sites. Therefore, an alternative proposal for the enhancement of integrated hospital care is to further develop closer links between maternity and general hospitals through

- Joint consultant appointments;
- Integrated care pathways;
- Agreed referral guidelines and protocols for access to consultant care and diagnostic services.

In addressing the issue of the location of future capacity, priority must be given to current infrastructure deficits that have clinical risk implications. This is particularly relevant to National Maternity Hospital (NMH) where approved proposals for interim infrastructure developments to address this issue should be implemented. However, the site of NMH is a constraint on future service development and therefore in the longer term the hospital should be relocated to an acute hospital site to allow for increased capacity if required. This relocation would also improve access for the catchment population both from a geographic perspective and in relation to access to specialised acute services.

To address the birth projections for 2011 for the catchment areas of each maternity hospital, it will be necessary to explore which hospital sites have the capacity within their current location to absorb the identified deficit matched to need. The feasibility of the development of additional capacity through public/private partnerships or private initiatives to meet service delivery demands on the public sector may also be explored.

Centralisation of some aspects of neonatal care is essential where the necessary skill, experience and technology will be available. Consequently, the national concentration of Level 3 care to a small number of units and Level 4 care to one or two units must be the goal. Level 4 care could be concentrated in one of the three Dublin maternity hospitals. Due to the high birth rate in the three Dublin maternity hospitals and their role as tertiary referral centres, all three hospitals should continue to provide Level 3 care and ideally in the future all three hospitals would also provide selected minor cardiology and surgical procedures on site.

Expansion of the neonatal transport service to a 24 hour/7 days a week service both for sick babies and also in anticipation of the immediate delivery of sick infants should be made available.

5.2 Workforce Planning and Development

Midwives, obstetricians, paediatricians, general practitioners, together with other medical, nursing, laboratory and allied health professionals, form an interdisciplinary team to provide maternity services for women and achieve optimal outcomes. The workforce must be of adequate size to deliver an effective, quality service and each member must be skilled, competent and up to date in clinical practice according to the level of service they provide.

As highlighted in the National Health Strategy (2001), "... professionals now practice in a more demanding environment. Evidence-based guidelines, tighter professional standards, the requirements of health-care organisations, and patient rights and expectations all add to these demands."

The interdisciplinary ‘maternity team’ approach is enhanced when it reflects certain criteria, which include:

- The provision of collaborative practice that is both woman-centred and evidence-based to ensure safety and choice for mother and baby;
- The full, collaborative use of complementary skills of obstetricians, midwives and general practitioners;
- The provision of continuity of care by such teams throughout the entire antenatal, birth and postnatal process;
- The development of excellent referral and communication procedures;
- Expansion of effective referral and communication procedures;
- The development of excellent referral and communication procedures;
Chapter 5: Future Capacity Requirements

• The combination of the above to support an integrated maternity service that will provide the different levels of care required by women.

Such a maternity team approach will need to clarify individual professional roles in relation to different models of care and will "...improve mutual respect and a culture promoting peer review and constructive re-validation of competence and performance".19

A number of current European and Irish policies have direct implications for the development of a workforce to provide future maternity services in the eastern region.

• The current national policy on staffing levels within the Irish health care system has set a maximum number of staff that may be employed on a permanent basis in each health service.

• Consequently, the heavy reliance on agency nursing staff has a negative impact on the continuity of care provided to women, staff satisfaction levels and workloads, and value for money.

Close cooperation between the education, training and professional bodies is required to ensure that training places match the demand for specific skills in maternity services. This is most effectively achieved through the coordination of workforce requirements across all health sectors at a national level.

5.2.1 Midwifery Workforce Planning

Recruitment and retention of qualified midwives has been an identified problem for the three Dublin maternity hospitals since approximately 2000. A report prepared by the Nursing and Midwifery Planning and Development Unit, ERHA, factors that influence the Recruitment and Retention of Midwives and Nurses in the Dublin Maternity Hospitals (2004), provides a comprehensive and in-depth analysis of influencing factors and makes recommendations on a number of initiatives to aid the recruitment and retention of nurses and midwives.20 Efforts to recruit abroad have been undertaken but the sourcing of candidates that meet the criteria for registration in Ireland under EU Directives has had limited success.

The following concerns have been highlighted in regard to midwifery workforce planning:

• As a consequence of the introduction of the degree of Bachelor of Science (Nursing) in 2002, virtually no nurses will graduate in Ireland in 2005 and the potential to recruit student midwives during 2005, 2006 and 2007 will be diminished. As the three Dublin maternity hospitals train a significant number of midwives for the country as a whole, this diminished recruitment will have a direct impact on the national potential for recruiting midwives. The proposed introduction of direct entry midwife education in 2006 is hoped to address this problem. The HSE will continue to work with maternity services, education providers, and the Department of Health and Children to monitor the impact on the workforce of direct entry midwifery and therefore minimise possible effects on services available.

• Midwifery and nursing staff levels within the Dublin maternity hospitals are based on historical complements that do not reflect the changes in maternity care e.g. increased use of epidural analgesia, higher Caesarean section rates, changes in neonatal care and developing models of maternity care.

• There are no agreed national standards for staff ratio or skill-mix in this area. In the United Kingdom the Department of Health, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists recommend the Birthrate Plus model of dependency assessment as an acceptable model for determining midwifery staffing levels. There is evidence that midwifery staffing within the Dublin maternity hospitals is below what would be recommended using this model.21

• A review of the skill mix of midwives, nurses, and maternity care assistants providing maternity care and the development of specialist and advanced midwife practitioner roles is required to be undertaken in alignment with the development of new models of maternity service delivery. The European Working Time Directive will also require greater utilisation of the professional skills of nurses and midwives and has implications for the development and expansion of the scope of nursing and midwifery practice.

• The increased complexity of care within neonatal services has caused a particular concern in workforce planning in this area. Almost 50% of midwives in the three Dublin maternity hospitals are recruited from abroad. Neonatal nursing education is not covered at a level required to develop expertise within any undergraduate education programme.

To ensure an adequate number of midwives in the future, effective recruitment and retention strategies will be vital and a multifaceted approach to recruitment and retention will be required. Strategies will need to include possible changes in education, skill mix, career opportunities, pay and conditions as well as clarification of roles and responsibilities. Models of care, which allow midwives to provide care across the continuum of pregnancy, childbirth and the postnatal period, will enhance the retention of midwives within the services and provide greater satisfaction for many midwives. A national pilot project introducing a maternity module of education for health care midwives assistants was piloted in The Rotunda Hospital in 2001-2002, evaluated and subsequently introduced.

In particular, the role of the advanced nurse practitioner in the area of neonatology should be supported and advanced, as fewer non-consultant hospital doctors (NCHDs) become available to staff neonatal units. Responding to need, the three Dublin maternity hospitals, in partnership with the Royal College of Surgeons in Ireland, have developed a Higher Diploma in Nursing - Neonatal Intensive Care.

5.2.2 Medical Workforce Planning

The maternity hospitals have identified the need for additional consultants in obstetrics/gynaecology as well as paediatrics, anaesthesia and microbiology/infectious diseases to address the ongoing increase in deliveries and complexities of care.

The development of community-based maternity services over the next six years for women with uncomplicated pregnancies or at low risk of developing complications, will allow the maternity hospitals to focus increasingly on the delivery of specialist care to women with, or at risk of developing, complex maternity needs. This increased focus on specialist care will increase demands on specialist staff.

The British Paediatric Association has agreed recommendations for staffing Neonatal Units and the Royal College of Anaesthetists has agreed standards for anaesthetic support. Meeting these...
guidelines is a continuing problem for the Dublin maternity hospitals.

**Obstetricians, Gynaecologists and Neonatologists**

The current number of neonatologists in the Dublin maternity hospitals is inadequate for a full, consultant-provided service. A national plan for the future development of neonatal paediatrics has been clearly identified in the Needs Assessment report.

In regard to consultant obstetricians, the Royal College of Obstetricians and Gynaecologists (UK) has a general guideline of 1 consultant obstetrician per 500 births. To provide a consultant-delivered service, the Report of the National Task Force on Medical Staffing22 has identified that overall consultant staffing will need to be increased significantly within the eastern region (from 41 to 68 (WTE) obstetricians and gynaecologists, and from 10 to 17 (WTE) neonatal paediatricians).

Implementation of the European Working Time Directive will also require an increase in consultant posts throughout the maternity hospitals.

**Anaesthetists**

Anaesthetists are crucial to the care of pregnant women who become seriously ill (e.g. severe edema, massive haemorrhage, pre-existing diseases such as congenital cardiac disease and asthma). These women are cared for either in high-dependency units within maternity hospitals or on maternity services report that up to 5% of women delivering require high dependency care and this will quickly in recent years. The potential that ICT technology (ICT) in health care has grown very substantially number of high-risk cases”.

**General Practitioners**

The role of the GP as a member of the interdisciplinary team is essential for the overall continuity of care for the mother and baby. An acute workforce shortage in relation to the availability of GPs in certain catchment areas of the eastern region has been identified. Attempts to address the shortfall are under way by increasing the number of training posts for GPs in the region.

**5.2.3 Allied Health Workforce Planning**

A diverse range of allied health professionals including laboratory staff, social workers, physiotherapists, pharmacists, radiographers, dieticians, amongst others, contribute to the delivery of maternity services. Workforce planning to estimate the demand and supply of each of the allied health professional groups within maternity services is required.

**5.3 Information and Communications Technology**

The use of information and communications technology (ICT) in health care has grown very quickly in recent years. The potential that ICT offers in facilitating access to clinical information, developing professionals’ competencies and knowledge and enabling the review and audit of practice is well established. However, its value to maternity services in Ireland is yet to be fully realised.

In order to realise a vision of integrated care, we must have integrated patient information. This will require the provision of an appropriate ICT infrastructure and culture. The use of ICT to communicate key clinical and administrative messages amongst members of the interdisciplinary/ multi-organisational team caring for a pregnant woman should be comprehensively implemented. The provision of such a system would allow for care to be woman-centred and not organisation-centred.

Specifically, the following developments should be prioritised:

- Providing access to the ‘internal’ hospital patient systems to outreach workers operating in health centres and patient homes;
- Communicating with general practitioners regarding patient information, i.e. laboratory and diagnostic results as well as delivery and discharge notices;
- Communicating with acute hospitals regarding advice, treatment, referral and transfer of women being cared for by two different hospitals;
- Consideration of an electronic client record.

The electronic client record23, if appropriately developed, supported and implemented, will allow the developments described above to be realised. Within the electronic client record there should be transmission of medical diagnostic images such as cardiotocograph (CTG) recordings, ultrasound scans and other test results. This will allow the development of the virtual antenatal or postnatal clinic operating between health care professionals in the hospital and the community.

The concept of telemedicine should be further developed to include specific applications to allow video conferencing in regard to direct patient care. Furthermore, telemedicine could improve training and education by developing professional support networks as well as developing clinical skills through workshops and computer-aided programmes for rehearsal of emergency procedures.

Another priority for maternity services is access to accurate and up-to-date information in relation to health care provided. The information needs to be clinically relevant, carefully defined, accurately collected, up to date and easily accessible.

Information management processes will need to be reviewed within maternity services on an ongoing basis to ensure these principles are implemented, and audit of practice should take place to ensure this as well as ensuring the appropriate use of information technology.

Specific proposed areas for development in the appropriate use of information technology include joint endeavours in relation to:

- Business continuity and disaster recovery;
- User help desk operations;
- Network management;
- Centralised procurement;
- Human resource alignment.

Casemix is a model used to categorise and quantify acute hospital activity. It is an international model and has been used in Ireland since the early 1990s. Casemix is based on the comparison of activity and...
Chapter 5: Future Capacity Requirements

Costs between hospitals. As the clinical workload of hospitals varies greatly, casemix is an attempt to categorise and quantify the ‘mix’ of cases by classifying patients into discrete classes or groups (Diagnosis Related Groups - DRGs) that share common clinical attributes and similar patterns of resource use. In Ireland, as with many other countries, casemix is also used to determine levels of funding to hospitals based on their ‘mix’ of cases. "Casemix categorises each hospital’s caseload into discrete groups. This allows the comparison of activity and costs between different hospitals - the essence of casemix."

Casemix is the only audited dataset of acute hospital costs and activity nationally.

At present, 37 of the main acute hospitals are included in the casemix process in Ireland monitoring inpatient, outpatient and day case activity. The coverage of the casemix system is constantly growing with plans to include more hospitals and affect a greater proportion of hospital budgets over the next few years. The three Dublin maternity hospitals were included in 2003 and are in their own peer group for comparison of activity, resources used and cost.

A multidisciplinary working group comprising the Joint Standing Committee of the Dublin Maternity Hospitals, Health Service Executive, and Casemix Unit. Department of Health and Children could inform the clinical analysis and interpretation of data collected from the maternity hospitals and would be linked with the national structures as outlined by the Department of Health and Children in the publication *The Modernisation of the National Casemix Programme in Ireland* (Government of Ireland, 2004).

Finally, the pivotal role of the three hospitals in relation to the efficient and effective register of births is of note. In conjunction with the General Registrars Office, adaptations to local ICT systems and procedures means that each hospital now facilitates the smooth registration of new births. The technology behind this will, in time, automatically trigger consequent government action on behalf of the citizen, such as commencement of child benefit, as well as forming a key starting point of a life-long health record for each citizen in Ireland.

Chapter 6: Next Steps

This strategy document identifies and explores a range of issues in maternity services in the eastern region that are important. It provides strategic directions for the development and implementation of future services.

- Development of maternity services in the eastern region must be integrated into and consistent with a national maternity service.
- Many of the foundations needed to sustain new models of maternity care are already in place. However, much has still to be done to build a system that is responsive to the individual needs of women and that uses the complementary skills of all maternity providers most effectively.
- This document provides the building blocks to improve maternity services in the eastern region to the benefit of the entire community and all of the women and care providers involved.

To move forward, a number of issues warrant focused attention and concerted action on the part of health professionals, health service managers, the Health Service Executive and the Department of Health and Children.

1. To implement this strategy, the development of a regional costed action plan and the establishment of regional and local implementation teams is required.
   a. The Health Services Executive will take a lead role in progressing the action plan. As a first priority, it is proposed to establish a regional strategic capital development plan that will be representative of the HSE, Joint Standing Committee of the Dublin Maternity Hospitals and the Department of Health and Children.
   b. The Joint Standing Committee of the Dublin Maternity Hospitals will take responsibility for implementation at a regional level.
   c. Individual hospitals will take responsibility for local implementation in line with the regional plan.

2. The need for collaboration and consultation between service providers and users to better determine needs and priorities is paramount. This collaboration and consultation is not only to ensure that services are safe, efficient and effective, but also that they are respectful, personalised and rewarding for both users and providers of maternity care

3. The establishment of a monitoring and evaluation framework will be required.
Appendix 1: Summary of The Women’s Health Council Consultative Process

**Priorities & Solutions suggested by consultation participants**

1. A good outcome. A safe delivery with no negative consequences for the mother or baby. This requires professionalism, accountability and good clinical care and practice.

Suggested solutions:
- More women could experience continuity of care through the extension of midwives’ clinics and through better planning and coordination between the three hospitals, and for the service as a whole. This is particularly important in the current context of staffing shortages and the high demand for the services offered;
- Increase choice, extend the early home and Domino schemes, and ensure that mothers are aware of their existence so that they can access them;
- Develop birthing clinics distributed throughout the region to bring care nearer to the women and to take pressure from the centralised maternity hospitals. Offer further opportunities for women to access the maternity services in the community before, during and after the birth.

2. Continuity of care. The same team caring for the mother throughout the pregnancy, from antenatal to delivery and postnatal care. The relationship built through this care process is particularly important to mothers and also of interest to the service providers.

Suggested solutions:
- More women could experience continuity of care through the extension of midwives’ clinics and through better planning and coordination between the three hospitals, and for the service as a whole. This is particularly important in the current context of staffing shortages and the high demand for the services offered;
- Increase choice, extend the early home and Domino schemes, and ensure that mothers are aware of their existence so that they can access them;
- Develop birthing clinics distributed throughout the region to bring care nearer to the women and to take pressure from the centralised maternity hospitals. Offer further opportunities for women to access the maternity services in the community before, during and after the birth.

3. Support and reassurance. The busy pace of the maternity hospitals, the lack of consistency in whom the mother sees at each visit and the antenatal appointments system currently result in insufficient time to provide support and reassurance for women at the level required.

Suggested solutions:
- Develop protocols to involve and support the busy partner,father of the birthing process and in the professionalism, expertise and confidence of the staff that deliver the service. A contextual finding from the consultation process is the recognition by users and providers that the current service relies on dedicated staff in the maternity hospitals who are working under very pressured conditions with resources stretched to the limit by the numbers of births each year and the nature of the facilities in which they work (old buildings and equipment). Providers feel the pressure of the current level of throughput in the hospitals and the users experience the service constraints resulting from this. Women who had had babies previously commented on the lower levels of service they experienced in the last year compared to three to five years ago. The pressure on staff has resulted in less than optimal time for individual women and their needs. This, together with the lack of continuity of staff in the care of women and the lack of full information to make an informed choice regarding their care, are key issues to be addressed. In addition due to various vulnerabilities or social circumstances, some population groups have significant difficulties with the services.

The Women’s Health Council hopes the cooperation that has been evident in conducting this review will continue so that measures are taken to ensure that the recommendations made by the participants can be adopted. This will ultimately improve the experiences of those who use and provide the maternity services in Ireland in the future.

**Summary of consultation**

In conducting this consultation process, considerable insight has been gained into the needs of both providers and users of the maternity services. There is a high level of satisfaction by pregnant women and new mothers in the outcome of the birthing process and in the professionalism, expertise and confidence of the staff that deliver the service. A contextual finding from the consultation process is the recognition by users and providers that the current service relies on dedicated staff in the maternity hospitals who are working under very pressured conditions with resources stretched to the limit by the numbers of births each year and the nature of the facilities in which they work.
Appendix 2: Committee Memberships

Strategic Planning for Maternity Services and Women’s Health Steering Committee

Chair: Louise McMahon

Members:
- Karen Burke: Service Planner, HSE-Eastern Region (from May 2004)
- Freda O’Neill: Specialist in Public Health Medicine, HSE-Eastern Region
- Kathleen McLaughlin: Resource Officer, Nursing and Midwifery Planning and Development Unit, HSE-Eastern Region (from July 2004)
- Sheila O’Malley: Director, Nursing and Midwifery Planning and Development Unit, HSE-Eastern Region (until July 2004)
- Alan Ashe: Chairman, The Rotunda Hospital
- Michael Lanhan: Secretary Manager, National Maternity Hospital
- Pauline Treanor: Director of Midwifery, The Rotunda Hospital
- Ita O’Dwyer: Director of Midwifery and Nursing, Coombe Women’s Hospital
- Grace Fisher: Director of Public Health Nursing, Community Care Area 10, HSE - Eastern Region
- Sean Daly: Master, Coombe Women’s Hospital (co-opted as required Dec-March 2005)
- Fidelma MacHale: Researcher, HSE - Eastern Region (co-opted as required Dec-March 2005)
- Willie Ruthgan: Service Planner, HSE - Eastern Region (until Sept 2003)

Joint Standing Committee of the Dublin Maternity Hospitals

Chair: Dr. Miriam Hederman O’Brien

Members:
- Alan Ashe: Chairman, The Rotunda Hospital
- Fintan Fagan: Secretary/General Manager, The Rotunda Hospital
- Michael Geary: Master, The Rotunda Hospital
- Pauline Treanor: Director of Midwifery, The Rotunda Hospital
- Brian Davy: Chairman, National Maternity Hospital
- Michael Lanhan: Secretary Manager, National Maternity Hospital
- Michael Robson: Master, National Maternity Hospital
- Mary Boyd: Director of Midwifery and Nursing, National Maternity Hospital
- Tom O’Higgins: Chairman, Coombe Women’s Hospital
- John Ryan: Secretary and General Manager, Coombe Women’s Hospital
- Sean Daly: Master, Coombe Women’s Hospital
- Ita O’Dwyer: Director of Midwifery/Nursing, Coombe Women’s Hospital
- Breeda Doyle: Secretary

List of Abbreviations

- ALOS: Average Length of Stay
- CSO: Central Statistics Office
- DOMINO: Domiciliary In and Out
- ERHA: Eastern Regional Health Authority
- GP: General Practitioner
- HSE: Health Service Executive
- ICT: Information and Communications Technology
- NHS: National Health Service, United Kingdom
- NICU: Neonatal Intensive Care Unit
- NMH: National Maternity Hospital
- WTE: Whole Time Equivalent
Glossary of Terms

Primary Care
An approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.

Secondary Care
Specialist care that is typically provided in a hospital setting.

Tertiary Care
Very specialised care, normally confined to a small number of locations.

Shared Care
Continuing care for those with on-going needs that is usually provided by both primary and secondary care providers.

Maternity and Infant Care Scheme
This scheme provides for free antenatal care for expectant mothers and medical care for infants up to the age of six weeks, irrespective of eligibility category. It is operated by general practitioners who have agreements with Health Service Executive regions to provide the services in return for specified fees.

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