



The Regulation and
Quality Improvement
Authority

press release

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RQIA publishes findings of Maternity Services Review

Today, the Regulation and Quality Improvement Authority (RQIA) published its review of care for women during labour and delivery and called for the development of a maternity strategy for Northern Ireland.

Speaking at the publication of RQIA's independent review of intrapartum care services, Chief Executive Glenn Houston said: **"At a time of a rising birth rate and reprofiling of maternity services, RQIA has undertaken a review to assess the quality and safety of care for women during labour and delivery."**

In the absence of specific intrapartum standards at the outset of the review, RQIA focused on the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, published by the Royal Colleges of Obstetricians and Gynaecologists, Midwives, Anaesthetists, and Paediatricians and Child Health. The review also took account of DHSSPS circular (2008), Lessons from Independent Reviews of Maternal Deaths and Maternity Services.

RQIA Chairman, Dr Ian Carson said: **"RQIA's review was carried out by an independent panel of leading national experts in obstetrics and midwifery. The review team makes a series of important recommendations for the service across Northern Ireland and specific recommendations for each trust."**

Dr Carson continued: **"The key recommendations include the need to maintain appropriate levels of obstetric, anaesthetic and midwifery cover; for all trusts to audit and review their midwifery staffing levels on an annual basis; and to provide all staff with protected time for mandatory training. Taken together, these provide further direction for improvements in the quality and safety of care for women in labour and during delivery."**

Glenn Houston concluded: **"RQIA commends the commitment and dedication of all staff working in maternity services. We particularly welcome the constructive response by trust staff in addressing the major learning points arising from regional and national serious incidents in maternity services. We also note the many positive comments from mothers who responded to the patient survey."**

"RQIA recognises the current pressures on the health service, and whilst some recommendations require additional resources, others may be achieved at no significant cost. We believe that the implementation of all the recommendations from this review will support the continuing improvement of maternity services in Northern Ireland."

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Editors' notes

About RQIA

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

What is intrapartum care?

Intrapartum care relates to care provided during labour and delivery.

RQIA Review of Intrapartum Care Services: Terms of Reference

The specific terms of reference for the review were to:

- profile the availability of maternity services, with a particular focus on intrapartum care, across the five health and social care trusts in Northern Ireland
- provide a baseline assessment of the quality and safety of care within maternity services, based on an initial assessment of the application of Safer Childbirth, Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatricians and Child Health, October 2007)
- consider clinical and corporate governance arrangements in place and, in particular, the reporting, investigating and learning from adverse incidents and near misses
- assess and comment upon the service user experience of maternity services across Northern Ireland to include patient centred assessment and care planning and the provision of information to service users
- report on the findings and make recommendations as appropriate

The terms of reference excluded pre-conceptual care, fertility treatment, antenatal and postnatal aspects of care as well as neonatal services.

At the time of planning the review there were no specific standards for intrapartum care in Northern Ireland. The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, (October 2007), was used as the framework for the assessment of services. It was considered that the standards and criteria would provide a robust framework against which to provide a baseline assessment of intrapartum care, even though they had not been formally agreed for implementation in Northern Ireland. The Review team also took account of the recommendations of a joint CNO/ CMO circular (DH1/08/133883) Lessons from Independent Reviews of Maternal Deaths and Maternity Services, issued in October 2008.

Independent Review Team Membership

The review team included a panel of independent experts from across the UK.

Dr Brian Alderman	Postgraduate Medical Education and Training Board (PMETB), London
Ms Janet Calvert	Regional Breast Feeding Co-ordinator, Health Promotion Agency, Northern Ireland
Dr Carole Castles	Lay Reviewer, Northern Ireland
Ms Jayne Jempson	Matron for Intrapartum Care, Portsmouth Hospitals Foundation Trust, Portsmouth
Ms Sara Johnson	Head of Child Health and Maternity Care, National Patient Safety Agency, London
Dr Kate Langford	Consultant Obstetrician, St Thomas' Hospital, London
Dr Tahir Mahmood	Vice President Standards, Royal College of Obstetricians and Gynaecologists, Fife/London
Ms Frances McMurray	Chief Executive, Northern Ireland Practice and Education Council, Northern Ireland
Dr Geraldine O'Sullivan	Consultant Anaesthetist, St Thomas's Hospital, London
Mr Phelim Quinn	Director of Operations and Chief Nursing Advisor, RQIA, Northern Ireland
Dr Elizabeth Reaney	Consultant in Public Health, Confidential Enquiry into Maternal and Child Health, Northern Ireland

Recommendations for Maternity Services across Northern Ireland

1. The Northern Ireland Maternity Services Information System (NIMATS) should be implemented in all maternity units across Northern Ireland.
2. All trusts should prepare an annual programme of audit activity in relation to maternity services and publish an annual report on the audit results which should be disseminated to members of the maternity team.
3. All trusts should ensure the harmonisation of policies and guidelines from those used by their legacy trusts and ensure that there are effective mechanisms to disseminate them to staff.
4. All trusts should review their structures and processes for the reporting and analysis of incidents and near misses in maternity services and ensure there is effective and timely feedback on a multidisciplinary basis.
5. All trusts should consolidate induction, training and practice in respect of written and electronic record keeping across all disciplines involved in providing maternity services and carry out regular audits of records.
6. Each trust should ensure that the terms of reference of its labour ward forums are clearly defined and that there are mechanisms for user involvement. Where there is more than one labour ward forum in a particular trust, steps should be taken to ensure regular communication between them.

7. The HSC Board and trusts should consider the adoption of a single assessment tool for midwifery staffing across Northern Ireland and the frequency with which it should be applied.
8. All trusts should review their senior and junior medical staffing for maternity units in relation to the Safer Childbirth Standards in conjunction with the HSC Board, DHSSPS and Northern Ireland Medical and Dental Training Agency (NIMDTA).
9. DHSSPS should develop a specific policy on the development of the role of consultant midwives across Northern Ireland, in line with its policy on the introduction of midwifery-led units.
10. All trusts should aim to have a consultant present for a physical ward round as appropriate and at least twice a day during Saturdays, Sundays and public holidays.
11. All trusts should have formalised written agreements in place with the Northern Ireland Ambulance Service on attendance at emergencies or when transfer is required.
12. Trusts who do not have dedicated 24 hour anaesthetic services should review their cover arrangements to ensure that there will be no delay in carrying out an emergency caesarean section.
13. All trusts must work to achieving an appropriate balance between managing rotas and providing protected time for training opportunities, for medical staff.
14. All trusts must ensure records of staffs' attendance at mandatory and other training sessions are regularly reviewed and that line managers are made aware of the reasons for non-attendance at mandatory training.
15. All trusts should establish a skills inventory for midwifery staff.
16. The proposed plan for the new maternity unit at the Royal Jubilee site should be revisited to take account of increased throughput and of the potential for further increases in activity as a consequence of the plans to re-profile maternity services on the Lagan Valley Hospital site, which may impact on referrals to the Belfast Trust.
17. All Trusts should explore further innovative ways to harness the views of service users and to utilise feedback from service users to bring about improvements in the birthing environment.
18. All trusts should review their information needs for maternity services to ensure that they have systems to provide the data set out in the Safer Childbirth Standards and that this information is effectively shared with staff.
19. The DHSSPS, Business Services Organisation (BSO) and trusts should work together to develop the capabilities of the NIMATS system and ensure that appropriate information is readily available on clinical outcomes as set out in the Safer Childbirth Standards.
20. DHSSPS should consider the development of a strategy for the future development of maternity services in Northern Ireland reflecting increasing birth rate trends, changes in working patterns and developments in obstetric and midwifery practice.

Trust Specific Recommendations

Belfast Health and Social Care Trust

1. There should be a clinical audit lead to direct multidisciplinary audit.
2. The trust in conjunction with the HSC Board should consider a future model for provision of maternity services at the Mater Hospital based on the document entitled 'The Future of Small Maternity Units', Royal College of Obstetricians and Gynaecology. This paper provides solutions for small obstetric units like the Mater, where service can be provided without the presence of doctors in training.
3. The trust should appoint a labour ward manager in the Mater Hospital.
4. The trust should ensure, through clinical support and supervision, that medical staff are fully supported and adequately prepared for the work undertaken in the birth setting.
5. The trust should continue to improve the birthing environment giving priority to the provision of piped gas and air facilities in the rooms at the Mater. They should also harness the view of service users to look at ways of making the environment in the Royal Jubilee less clinical and more homely where possible.

Northern Health and Social Care Trust

1. The trust should explore ways to strengthen the on site midwifery leadership at night and reduce the need for the band 6 midwives to call the band 7 midwives for advice on patient management.
2. The trust should ensure that all midwifery staff have regular rotation, around all areas of practice, and that there is a system of rotation on and off night duty.
3. To help achieve appropriate levels of consultant presence on labour ward, the trust should review clinic provision with a view to implementing a phased reduction of peripheral clinics.
4. The trust should continue to pursue the establishment of an early assessment unit and a midwifery led care model at Antrim Hospital.
5. The trust should identify a lead obstetric anaesthetist for anaesthetic services at Causeway Hospital.
6. The trust should consider developing a high dependency care facility close to the labour ward in Antrim.
7. The trust must ensure they have robust procedures to ensure consultant obstetricians are available within 30 minutes and that this is reviewed on a regular basis.
8. The trust should take into the account the requirement for a bereavement room when developing their plans to provide a close monitoring room / high dependency area at Antrim Hospital.

Southern Health and Social Care Trust

1. The trust should develop a specific risk management policy for obstetrics ensuring that this includes a clearly defined trigger list for incident reporting.
2. The trust should consider the appointment of a designated risk management midwife to strengthen and build upon existing arrangements and assist in the development of a rolling programme of audit.
3. The trust should review provision of anaesthetic cover in the Craigavon and Daisy Hill hospitals given the nature of the case mix in both units.

South Eastern Health and Social Care Trust

1. The trust should consider the viability of having a reception room for those women who require elective caesarean section or induction of labour.

Western Health and Social Care Trust

1. The trust should implement the new arrangements for quarterly risk management meetings without delay, staff from across the trust should be facilitated to attend these meetings.
2. The trust should ensure a documented procedure is in place for the dating, archiving and central storage of past guidelines.
3. The trust should develop a policy for the wearing of identification badges.
4. The trust should develop appropriate procedures to ensure staff have an appropriate level of competency in English.
5. The trust should identify a lead obstetric anaesthetist for anaesthetic services at the Erne Hospital.
6. The trust should take into account the requirement for a bereavement room when developing their services at the Erne Hospital.