



THE ROYAL
COLLEGE OF
MIDWIVES

—
**DELIVERING BETTER
MATERNITY CARE**
—

—
**THE CASE
FOR A NEW
MATERNITY
STRATEGY FOR
NORTHERN
IRELAND**
—

EXECUTIVE SUMMARY

More than a decade has now passed since the Department of Health¹ started the review that led to the publication of its *Strategy for Maternity Care in Northern Ireland 2012–2018*.

That strategy helped deliver many improvements in maternity care across Northern Ireland, but it came to an end three years ago. We need a new, refreshed strategy for the decade ahead.

With over 20,000 births in Northern Ireland every year², it is vital that we get the delivery of maternity services right. It has such a profound impact on so many lives, impacting the health of both the woman and her baby.

Maximising the contribution midwives make to improving population health and wellbeing outcomes benefits women, empowering them to make healthy choices in pregnancy. By supporting women to achieve optimum health in pregnancy, midwives help to reduce future morbidity, mortality and health inequalities for women, children, and families. The vital importance of that work underlines why we cannot just let maternity services drift along on a course first set down a decade ago.

The need for a renewed maternity strategy for Northern Ireland, informed by a thorough review of services, grows more urgent with every passing day.

Events such as the COVID-19 pandemic has focused our attention on the changes that were made across Health and Social Care (HSC) to enable us to respond to women and provide the care they require. This has further emphasised the need for a strategic overview of maternity care and how the service can and has addressed the pressures impacting on it and how that has evolved over time. We need to take a step back and evaluate whether we are on the right course or the wrong track.

Finally, recent reports into the safety of maternity care in other parts of the UK, such as the Ockenden Review into failings at Shrewsbury and Telford Hospital NHS Trust, must inform any review of services here in Northern Ireland.

In this document we look back at the former strategy, examine some developments that illustrate the case for a new strategy, and suggest some areas of focus for those who draw up a new strategy for maternity care in Northern Ireland.

We stand ready to contribute to that new strategy and help chart the right course for our maternity services into the next decade. ■

Karen Murray

Director, Royal College of Midwives Northern Ireland

¹ Prior to May 2016, Northern Ireland's Department of Health was known as the Department of Health, Social Services and Public Safety. That was its name at the time of the review of maternity services and the subsequent strategy, but for consistency we use its current name throughout this document.

² *Monthly Births*, Northern Ireland Statistics and Research Agency, 11 January 2021, <https://www.nisra.gov.uk/publications/monthly-births> (accessed 14 January 2021)

PART 1: ANALYSIS OF THE STRATEGY FOR MATERNITY CARE IN NORTHERN IRELAND 2012–2018

In summer 2020, the Maternity Strategy Implementation Group submitted its end-of-strategy report to the Department of Health’s Chief Medical Officer and Chief Nursing Officer³.

This report set out the progress in implementing the previous [2012–18] strategy but the Minister of Health has said that because of the challenges posed to his Department by the pandemic, “consideration of the report has been somewhat delayed” and that the report would be published “as soon as is possible ... if appropriate”.

The Royal College of Midwives (RCM) believes that the report should be published nonetheless, whether or not it has been considered by the Department. It is clearly in the public interest for such a report to be published while its findings are still relevant and can be acted upon.

In the absence of the end-of-strategy report, we must turn to the review and 19 recommendations published by the Regulation and Quality Improvement Authority (RQIA)⁴ in 2017.

It is important to state that this report found good progress in relation to taking forward the goals and objectives of the strategy. It is helpful too that the review suggests that simply the existence of a strategy helped mobilise and focus the work of staff, including leaders. It also found that the strategy had helped improve care for women. These improvements were achieved despite the fact that there were “no additional ring-fenced resources” given to the HSC to help deliver on the strategy⁵.

It is telling however that the RQIA report, even though it was written prior to the end of the 2012–18 strategy,

already noted that parts of the strategy were becoming outdated. It noted, for example, the growing complexity and acuity of the maternity workload. Workforce, including the issue of age profile and its implications for retirement, were also identified as continuing problems.

It is noteworthy that even at the time the RQIA review was written there were parts of the health system that were not particularly aware of the strategy. GPs were named as an example. If that was true even during the lifetime of the previous strategy, how likely is the health system to be prioritising maternity care now when there is no live strategy available?

It would be useful to see how the findings of this 2017 report compare with the end-of-strategy report submitted to the Department last summer. Were the RQIA’s 19 recommendations acted upon? What progress was made? What are the outstanding issues that have been identified going forward?

It is clear in the RQIA report that more work remains to be done. This is of course an ongoing process, which is all the more reason we need a new review followed by a new strategy to take maternity care in Northern Ireland forward.

Our top recommendation here is that the strategy review that the Department has had in its possession since summer 2020 is published without delay. The Department is facing intense and entirely understandable challenges in coping with the pandemic, so let midwives working in the system as well as organisations like the RCM and others see the report and seek to learn the lessons identified within it. Trust the professionals. ■

³ Confirmed by the Minister of Health on 13 November 2020 in answer to a written question from Rachel Woods MLA.

⁴ *Review of A Strategy for Maternity Care in Northern Ireland (2012-18)*. Regulation and Quality Improvement Authority, March 2017, <https://www.rqia.org.uk/RQIA/files/3d/3d4d9d13-8079-403f-80d6-ee79008718da.pdf>

⁵ Confirmed by the Minister for Health On 9 February 2021 in answer to a written question from Rachel Woods MLA.

PART 2: WHY DOES NORTHERN IRELAND NEED A NEW MATERNITY STRATEGY?

Learning lessons from the pandemic

The pandemic has forced health services across the world to change how care is delivered. That has included maternity care in Northern Ireland.

Some of those changes have been positive. Take, for example, the fact that all maternity units in Northern Ireland set up helplines to enable women with any concerns or issues to ring and speak directly to a midwife. These lines were often staffed by midwives who were shielding and therefore unable to take on face-to-face roles within the service. The helplines ensured women's concerns could be addressed promptly, by a midwife; calls could be triaged and arrangements made for women to attend hospital or be seen by their community midwife. Crucially, this system diverted calls that would normally have gone directly to staff in the maternity units. This resulted in the hospital based staff being free to provide direct clinical care.

Another example of clinical innovation was the development of community hubs in many areas. These one-stop shops enabled women to attend appointments for antenatal reviews and postnatal clinics at times that suited them. Setting up and prioritising the hubs during the pandemic ensured that all antenatal and postnatal care was provided and not stood down. Women appeared to appreciate the ability to have an appointment time and having the hubs also facilitated continuity of carer for both antenatal and postnatal contacts.

This innovation was not without its difficulties, particularly the availability of appropriate spaces. Added to that, not all women are able to travel to hubs, with home visits continuing for these women.

In March 2020 all face-to-face antenatal education classes were stopped because of the pandemic. In response, the Public Health Agency (PHA) provided free access to virtual antenatal and postnatal education classes online. Additionally, many services developed and started to provide programmes like

support for breastfeeding through platforms such as Zoom. This enabled interaction between expectant parents, local midwives and other parents, all while accessing sessions from their own homes. Of course, access to these platforms is dependent on having the appropriate access to technology and Wi-Fi connectivity, which will not be available to all women.

Not every change was positive. Take booking appointments as an example. These were widely facilitated remotely with women attending clinics only for their viability scan and baseline observations. Booking interviews were largely conducted remotely to reduce the amount of time midwives and women spent in close proximity. Many midwives reported feeling that they did not have the same level of interaction with women and worried that they did not have the same opportunities to pick up on important non-verbal cues.

These are just some examples of how the pandemic has demanded a response which has accelerated ideas and plans which could influence longer-term change in how we deliver maternity services in Northern Ireland.

Good and bad, these changes represent a dramatic shift in how services could be delivered in the future. They illustrate starkly just how much care is changing, and therefore how much we need a new, refreshed strategy to guide the future course of these changes.

We need to evaluate these innovations and develop the learning to ensure we do not go back, but rather travel forward and plan services informed by the experiences of the women and midwives. Some of these changes will be implemented as effective alternatives and others may be abandoned in favour of previous models of care that we know work and deliver safe quality care. Put simply, let us decide what works well and make it happen.

This process, for delivering maternity care, could be very effectively incorporated into a wider strategic review of the service.

Northern Ireland’s changing demographics

Some public services get a degree of warning of the demands that will be placed on them in future years. Secondary schools, for example, can have a good idea of how many pupils they will need to cater for as those children progress through primary schools. And primary schools themselves can keep an eye on what is happening with births to know whether they will need to accommodate more or fewer pupils in future years.

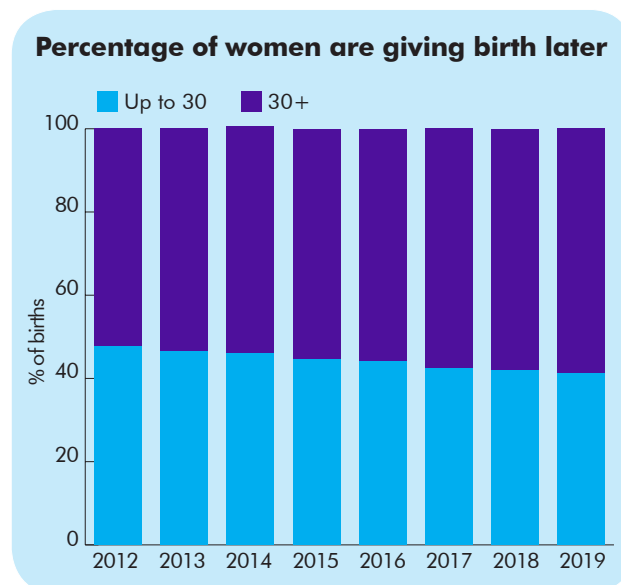
Maternity services have much less warning. The number of births can rise or fall without notice. Some years the trend in the number of births will simply continue as before. In other years it may go into reverse, turning a consistent rise into a fall or a historic downward drift into a new baby boom. Changes can happen faster – much faster – than the speed at which midwives can be trained and recruited into the HSC.

The number of births in Northern Ireland has been edging downwards in recent years⁶. During the scope of the old strategy (2012-2018), the number of births fell by just under 10 per cent, from 25,269 to 22,829. Before the pandemic disrupted the collection of monthly birth statistics, January 2020 actually saw more births (2,361) than in any year since 2013 (when there were 2,362 births). Maternity services must always remain flexible and with some inbuilt additional capacity to cope with any unexpected upturn in birth numbers.

However, it is not simply the number of babies born that we need to measure. We also need to consider the demographics of the women giving birth to inform the resources that are needed to care for

them. The more medical and social complexity, the more staff and other resources are needed to provide safe, quality care.

Women are giving birth later, for example⁷. The proportion of births that are to women aged under 30 fell between 2012 and 2019, from almost half (47.6 per cent) to just over two in five (41.3 per cent). Around one birth in four (24.0 per cent) is now to women aged 35 or older. The number of births to the oldest women accessing maternity care in Northern Ireland (aged 45+) is small but rising – up from 46 to 61 during this period. This is a trend we have seen across the UK.



One indicator that is going in the wrong direction in terms of public health is the proportion of women accessing maternity services in Northern Ireland who are obese. Between 2015 and 2019, this figure rose by a quarter from 20 per cent to 25 per cent⁸. Women who are obese during pregnancy need more care and closer monitoring than women who are not.

⁶ *Monthly Births*, Northern Ireland Statistics and Research Agency, 11 December 2020, <https://www.nisra.gov.uk/publications/monthly-births> (accessed 22 December 2020)

⁷ *Registrar General Annual Report 2019*, Northern Ireland Statistics and Research Agency, 16 December 2020, <https://www.nisra.gov.uk/statistics/births-deaths-and-marriages/registrar-general-annual-report> (accessed 14 January 2021)

⁸ Statistics relating to obesity, smoking status and high blood pressure provided in the ministerial answer to a written question asked in the Northern Ireland Assembly by Alex Easton MLA, 22 September 2020, <http://aims.niassembly.gov.uk/questions/writtenssearchresults.aspx?qf=0&qfv=1&ref=AQW%206365/17-22> (accessed 22 December 2020)

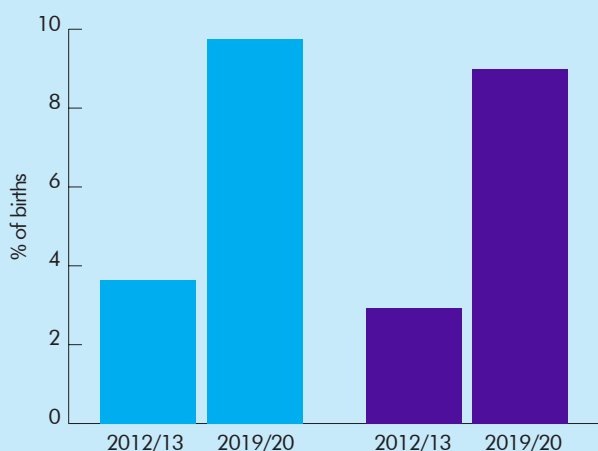
This can often mean more appointments, and longer appointments. This is a development that would potentially benefit from the kind of analysis and review that a new strategy would bring.

Linked to the greater incidence of obesity, we are seeing the prevalence of diabetes amongst pregnant women increasing significantly. In 2019/20, 9.75 per cent of births were to mothers with diabetes compared to 3.64 per cent in 2012/13. Much of this increase can be attributed to an increase in women identified with gestational diabetes, which rose from 2.92 per cent in 2012/13 to 8.98 per cent in 2019/20.

Diabetes during pregnancy can place the woman and her baby at greater risk of serious health complications. The identification of women who have pre-existing diabetes or who are at an increased risk of developing gestational diabetes is another example of how good maternity care can contribute to improved public health, putting prevention and early intervention at the centre of midwifery practice.

Prevalence of diabetes amongst pregnant women

■ Births to mothers with diabetes
■ Increase in women identified with gestational diabetes



Little progress has been made in recent years on reducing the proportion of women using maternity services in Northern Ireland who are smokers. The rate edged down from 15 per cent to 13 per cent between 2014 and 2018. Much more progress is needed here, and a new strategy could help design that new approach.

The proportion of women who have high blood pressure rose slightly from three per cent to four per cent between 2015 and 2019. For some women, pregnancy will be the moment when high blood pressure or another long-term health condition is identified, which might otherwise have gone undiscovered and undiagnosed for many years. This illustrates very clearly the value of good maternity care in the delivery of improved public health more generally putting prevention and early intervention at the heart of midwifery practice – another potential focus for a renewed maternity strategy.

18.9%
of women reported a
history of at least one mental
health disorder

There has also been a rise in the number of women with mental health problems. A recent study found that almost a fifth of women (18.9%) reported a history of at least one mental health disorder⁹. Mental health disorders in pregnancy are common causes of morbidity and mortality, with associated risks of adverse neonatal outcomes. The identification, support and appropriate referral of women with mental illness is important to protect the health of both the mother and the future health of the newborn.

⁹ Mongan, D., Lynch, J., Hanna, D., Shannon, C., Hamilton, S., Potter, C., Gorman, C., McCambridge, O., Morrow, R. and Mulholland, C., 2019. Prevalence of self-reported mental disorders in pregnancy and associations with adverse neonatal outcomes: a population-based cross-sectional study. *BMC Pregnancy and Childbirth*, 19(1).

Given this, it is welcome that additional funding has been announced to create specialist perinatal mental health services across Northern Ireland¹⁰. It is unfortunate however that there remains no commitment to create a dedicated mother and baby unit for women in need of such services. No such unit exists in either Northern Ireland or Ireland despite research¹¹ showing that such units have clear clinical benefits as well as being cost-effective.

Additionally, there are important factors beyond the physical and mental health of women. One trust, for example, saw a rise of around a third (31 per cent) between 2018 and 2020 in the number of referrals to social services. In one area covered by another trust, an audit identified almost a third of women have had safeguarding concerns raised.

More widely, we have also seen rises in the number of women struggling with alcohol and drugs. All of this inevitably has an impact on the mother and baby.

These women will need intensive support from their midwives as well as from other members of the wider multidisciplinary team, all of which has significant implications for the size of the workforce required. As just one example, with regard to social service referrals, midwives need sufficient time to prepare for and attend case conferences.

The service needs to analyse this evolving situation and examine the workforce implications of the changing complexity of the midwife's caseload.

Changes to how maternity services are being delivered in Northern Ireland

Northern Ireland is witnessing changes in how maternity services are being delivered to women.

Take, for example, midwife-led units (MLUs). Between 2018 and 2019, the number of births taking place in MLUs in Northern Ireland rose by 446 or 15 per cent, with the new birth centre at the Royal Jubilee Maternity Hospital in Belfast seeing over 500 births in 2019 alone.

446

The rise in the number of births taking place in MLUs in Northern Ireland between 2018 and 2019

This rapid rise in the number of births taking place at MLUs has occurred since the end of the strategy. Between 2015 and 2018, the rise was just 14 births, or less than 0.5 per cent. This trend should be explored further to understand the possible positive impact of the changes in service delivery which may have resulted in this model of care being chosen by more women. It would be useful for a new strategy to reflect upon, understand and seek to accommodate this choice for more women.

The RCM believes that every woman in Northern Ireland should have the realistic option of giving birth in a MLU, with capital funding made available to help develop midwife-led options where this is not currently available and where supplementary MLU provision is warranted by demand. Resources should also be committed to promote the benefits of birth in an MLU so that women can make informed choices about where to give birth.

¹⁰ Northern Ireland specialist perinatal mental health service to help new and expectant mums, *Belfast Live*, 13 January 2021, <https://www.belfastlive.co.uk/news/health/northern-ireland-specialist-perinatal-mental-19617230>

¹¹ Mongan, D., Lynch, J., Hanna, D., Shannon, C., Hamilton, S., Potter, C., Gorman, C., McCambridge, O., Morrow, R. and Mulholland, C., 2019. Prevalence of self-reported mental disorders in pregnancy and associations with adverse neonatal outcomes: a population-based cross-sectional study. *BMC Pregnancy and Childbirth*, 19(1).

Caesarean section (CS) rates also seem to be higher than they were across Northern Ireland, compared to the picture that existed during the lifespan of the strategy. Between 2018/19 and 2019/20, for instance, the CS rate in the Southern HSC Trust area rose from 33 per cent to 35 per cent (higher than at any time over the previous five years). Western HSC Trust area also witnessed a rate higher than previously (rising from 31 per cent to 34 per cent in a year). Northern HSC Trust saw a jump from 32 per cent to 34 per cent, again the highest in recent years. South Eastern HSC Trust had a smaller rise, 32 per cent to 33 per cent, but this was also a recent high, and the rate had been below 30 per cent as recently as 2016/17. Belfast NHS Trust had the lowest rate (29 per cent), but this was also up and at a joint recent high.

These compare with a UK-wide figure of around one in four¹².

These changes and more are happening right now. We need a new maternity strategy to examine them, look at them in context, and set out a way forward to improve care and services for women and to try to tackle some of the challenges that are emerging.

And while it is not a change on previous years, the level and pattern of homebirth is worthy of investigation. Northern Ireland has only seen about 250 homebirths since 2015/16, a lower proportion than elsewhere in the UK, with the Northern HSC Trust area responsible for about half of them. The pandemic has seen a significant rise in demand for homebirth placing additional pressures on the community midwifery teams to cover on-call rotas and continue with routine workloads. Observations such as this help make the case for a new strategy – the opportunity to look afresh at ways in which Northern Ireland differs from neighbours and other international comparators:

not in terms of its institutional structures, but in terms of its systems, how it runs and operates the service.

One significant way in which maternity care in Northern Ireland can be improved is through greater continuity of midwifery carer.

There is compelling international evidence that continuity of midwifery carer – with women receiving care from the same midwife or small number of midwives – leads to safer, more personalised care, with benefits to mother and baby.

A Cochrane review (Sandall 2016), for example, showed that continuity of midwifery care had significant benefits. These included the woman being seven times more likely to be attended at birth by a known midwife, being less likely to lose their baby (16 per cent), less likely to lose their baby before 24 weeks (19 per cent), less likely to experience preterm birth (24 per cent), less likely to need regional analgesia (15 per cent), and more likely to have more positive maternity experiences. At the same time, there were no identified adverse outcomes when compared to women receiving shared or obstetric-led care.

Continuity of midwifery carer has received a huge boost in recent years as part of the maternity services transformation agendas across the UK. It is also a key part of the new standards of proficiency for midwives, published in November 2019 by the Nursing and Midwifery Council, the profession's regulator. These standards of proficiency represent the knowledge, understanding and skills all midwives must demonstrate.

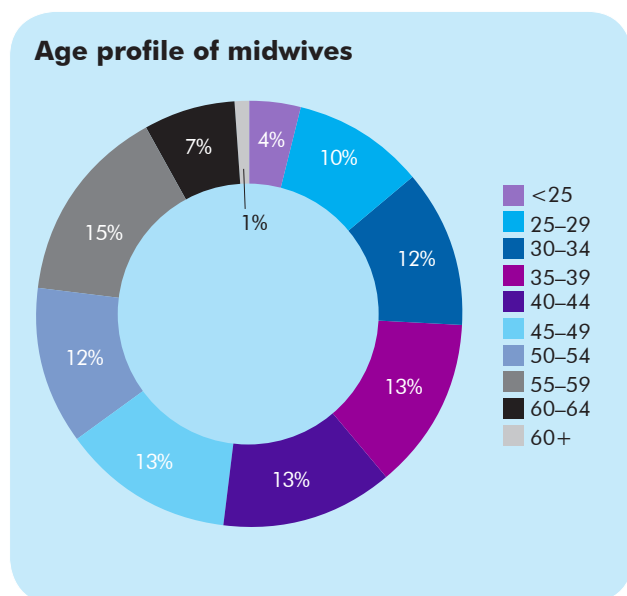
Here in Northern Ireland, as part of the Chief Nursing Officer's *Future Nurse Future Midwife* work, we have recommendations for how we implement continuity of midwifery carer and those must form part of any wider strategic review. ■

¹² nhs.uk. 2021. *Caesarean section*. [online] Available at: <<https://www.nhs.uk/conditions/caesarean-section/>> [Accessed 16 February 2021].

PART 3: WHAT SHOULD THE NEW STRATEGY BE ABOUT, AND WHAT WILL WE NEED TO DELIVER IT?

The deep challenges facing Northern Ireland's midwifery workforce

The size of the midwifery workforce in Northern Ireland is remarkably stable. In March 2020, according to the NI Health and Social Care Workforce Census, there were the equivalent of 1,092 full-time midwives working in the HSC. Two years earlier (2018) this was 1,090. Five years before that (2013) it had been 1,086¹³.



However, stability does not necessarily mean there are no problems. Stability can, for example, mask a problem with the age profile of midwives. Indeed, in last year's annual workforce census, the largest age group was midwives in their late fifties, and there were more than twice as many midwives in their fifties than in their twenties¹⁴. The obvious, clear risk with a workforce that skews older is that, at a certain point, midwives will be retiring at a faster rate than they can be trained.

The focus will need to be on training new midwives. There is little evidence that there are meaningful numbers of people in Northern Ireland trained to work as midwives who are not currently working as midwives.

Added to that, the system for training midwives has a limited capacity to flex to deliver whatever number of new midwives are needed. Universities only have so many midwifery academic staff and units themselves can only offer so many clinical placements to help student midwives train.

It is positive that student midwife numbers are now rising but it will take time for these students to qualify and join the workforce. In the meantime, it is imperative that support, such as preceptorship (a process which helps new midwives to develop and grow in confidence in their initial years in the profession), is readily available.

Considering the age profile of the workforce it is likely that the balance between older, more experienced midwives, and younger, newly qualified midwives will become skewed for a time. Careful consideration will need to be given to ensuring these newly qualified midwives get the support they need to help them remain in the profession long-term.

Properly understanding the issues in the workforce would also help inform decisions about how to maximise the system's ability to retain midwives, as well as understand the physical demands being placed on older midwives and how best to mitigate the associated risk of injury.

We also need a new focus on improving overall job satisfaction, both to keep them in post but also to

¹³ NI Health and Social Care Workforce Censuses, NI Department of Health, <https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/workforce-statistics>

¹⁴ NI Health and Social Care Workforce Census, March 2020, NI Department of Health, <https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-workforce-census-march-2020>

encourage them to maintain and extend their skills. Maximising the contribution of midwives, promoting and developing enhanced skills and roles, expanding leadership roles such as Lead Midwife or Consultant Midwife, increasing specialist midwife posts and providing clear career pathways will enhance the attractiveness of midwifery as a career.

70%
**the level of part-time
working amongst midwives
in Northern Ireland**

This kind of deep analysis of the midwifery workforce is just what is needed. This is an issue that we need fully to explore and understand. Take part-time working, for example. There are high levels of part-time working amongst midwives in Northern Ireland, over 70 per cent. Is this because the system is short of midwives and people need to reduce their hours to avoid stress and burnout? Is it because of the age profile, with older midwives wanting to reduce their hours as they approach retirement, or because of caring commitments? Is it an attempt to achieve work life balance for childcare? How best can the system incorporate part-time working, or make changes to allow midwives who want to work more hours to do so?

We also need a thorough analysis of vacancy rates. There does appear to us to be a discrepancy between published vacancy rates and the intelligence we receive from the frontline.

We know that in many services there are a number of midwives who have 'retired and returned.' These

midwives are essential to the service and often help to fill the gaps where services are short-staffed, but this is also the very reason why their employment can mask shortfalls in recruitment.

Equally, the level of reliance on 'bank hours' to fill rotas also provides an indication of shortfalls in recruitment. In one Northern Ireland maternity ward over 1,600 bank hours (where existing staff work additional hours) were used in March 2020. In September 2020, over 1,800 hours were required. This is the equivalent of over 11 full-time midwives per week.

Despite the acknowledged pressures of the pandemic this reflects a significant additional workforce need. It is important to acknowledge that expensive agency midwives are not routinely used in Northern Ireland. Bank hours are worked by midwives already employed by trusts. Given these figures, bank working represents a significant additional amount of work being undertaken by midwives over and above their existing, contracted working hours. This is less than ideal.

Indeed, this can have a significant impact on wellbeing, particularly given the older age profile of the workforce and the reported sickness levels. There is a serious need to consider how to support the retention of midwives while ensuring the ability to provide women-centred services, such as homebirths and continuity of midwifery care.

In addition to the issues mentioned above, this report also sets out ways in which the service is changing. It would be remarkable if these changes did not have an impact on the true number of midwives needed to provide a service that is as safe and effective as it can be.

³ Confirmed by the Minister of Health on 13 November 2020 in answer to a written question from Rachel Woods MLA. Review of A Strategy for Maternity Care in Northern Ireland (2012-18), Regulation and Quality Improvement Authority, March 2017, <https://www.rqia.org.uk/RQIA/files/3d/3d4d9d13-8079-403f-80d6-ee79008718da.pdf>

⁴ Confirmed by the Minister for Health On 9 February 2021 in answer to a written question from Rachel Woods MLA.

Overall, there is a clear case for a thorough analysis of the midwifery and maternity support worker workforce in Northern Ireland. These are issues that need to be explored and questions that need to be answered.

Delivering Care is the policy framework for the nursing and midwifery workforce planning in Northern Ireland. The Chief Nursing Officer, as the policy lead for the project, has requested that midwifery needs are now included into the next phase of work. This is a welcome move and one which we have been campaigning for over many years. Given the lack of strategic framework to determine the future organisation of maternity services however we are concerned that determining workforce needs for services now will not reflect the workforce needs for a transformed service in the future.

A new strategy is the place to assess Northern Ireland's maternity workforce needs and make recommendations for meeting them now and in the long term. One cannot train a midwife overnight.

Supporting midwife leaders in Northern Ireland

Delivering any new strategy and effective change in the long term requires strong professional leadership. The RCM believes midwifery leadership can be strengthened right across the UK, including in Northern Ireland, by implementing the seven steps set out in the RCM's midwifery leadership manifesto¹⁵, namely:

1. A Director of Midwifery in every trust, and more Heads of Midwifery across the service. We need a stronger midwifery leadership voice across the service.

2. A Lead Midwife at a senior level in all parts of the HSC. As well as the parts that deliver maternity services directly to the public, there are other bodies involved in the delivery of healthcare. They monitor how well providers are doing, plan the future workforce, regulate staff, amongst many other functions. These bodies need a senior midwifery voice too.

3. More Consultant Midwives. These are highly experienced and acknowledged clinical experts in their field. They lead, support, coach, mentor, inspire and empower their midwifery colleagues. They are leaders with both the responsibility and the ability to evaluate, develop and improve the provision of maternity services. We need more of them.

4. Specialist midwives in every trust. They provide expert advice to colleagues and to women and their families. They act as a resource on issues relating to their area of specialism, championing improvements in the trusts where they work. We need to expand this role.

5. Strengthen and support sustainable midwifery leadership in education and research. It is not just the HSC that plays an important role in delivering the midwifery workforce we need. Our universities train the next generation of midwives and they employ the teachers and academic researchers whose work we rely upon to improve maternity care.

¹⁵ Strengthening midwifery leadership: a manifesto for better maternity care, Royal College of Midwives, August 2019, https://www.rcm.org.uk/media/3527/strengthening-midwifery-leadership-a4-12pp_7-online-3.pdf (accessed 22 December 2020)

6. A commitment to fund ongoing midwifery leadership development. Organisations that offer career progression and personal development in leadership and management are more likely to attract and retain talent, and RCM members tell us that they believe leadership and management training will improve their personal performance.

7. Professional input into the appointment of midwife leaders. Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services.

A focus on midwifery leadership and the retention of midwives through clear career pathways to leadership roles is an essential component of the strategy to ensure that the midwifery voice is strong when it comes to advocating for the high quality, safe maternity services that all of us strive to provide.

We need to invest to get maternity care right.

In this document, we make the case for a renewed maternity strategy for Northern Ireland. But a strategy alone would be insufficient to deliver the change needed. Alongside any strategy we must also see the financial resources needed for its implementation.

We need to see investment in workforce. In particular, funds must be earmarked to resource in full the implementation of the findings of the Delivering Care project. That would make sure that we have the right number of midwives to meet the needs of women and their families.

We need the right number of midwives to ensure a safe service, but of course safety is more than just about workforce. We need a protected allocation of money to maternity services for the full implementation of the safety agenda. The Maternity Quality Improvement Collaborative has been an effective multi-professional regional group which has made a significant contribution to ensuring a regional approach on safety critical initiatives. However, we would now seek a commitment that Recommendation 2 from the RQIA Review of A Strategy for Maternity Care in Northern Ireland (2012–18) namely “*The DoH should consider the development of a maternity network with similar levels of accountability to the neonatal network*” is implemented to continue to build on the success of the Maternity Collaborative. Funding for this initiative is critical to ensure that findings from national reports such as the Ockenden review of maternity services, *Saving Babies Lives* and *Each Baby Counts* are implemented.

We also need to see improvements in how money flows around the health system. In particular, money needs to follow the women across bureaucratic boundaries. Take as an example a woman who receives antenatal and postnatal care from community midwives from one trust but who gives birth in a unit operated by the neighbouring trust. Both trusts should receive funds necessary to pay for the services they provide; at present, that doesn't happen.

Additionally, in this paper we have outlined the ways in which developing the leadership potential of midwives would improve maternity care across Northern Ireland. Fundamental to that is the need for investment in education and training, knowledge, skills, and expertise across midwifery practice, education, management and research. ■

CONCLUSION

A decade has now passed since work started on the last maternity strategy for Northern Ireland, and it is three years since that strategy came to an end. The need for a strategy for maternity services in Northern Ireland has not disappeared. Indeed, the case for a new strategy is strong. This report has identified several areas that should form the focus for a new strategy for maternity care in Northern Ireland.

The past year has presented many challenges for maternity services, innovation in how care is delivered has been central to the response. Some of these innovations should be retained as we find a new post-pandemic normal; others should be discontinued. A strategic review of maternity services is a good place for an evaluation of these innovations to take place so that learning and experience can inform the new strategy.

The changing demographics of women using maternity services in Northern Ireland have been highlighted. The increasing health and social complexity of women, for example, demands different things from maternity services than has been the case in the past. We have also described how the service itself is already changing. The growth of births in MLUs is an example of that. There is a need to consider how best to respond to these changes and ensure that maternity services continue to make a significant contribution to improved public health.

Finally, we have outlined the significant challenges facing the midwifery workforce. Work which has already commenced as part of the *Delivering Care*

policy framework must inform a new maternity strategy with concrete recommendations for maternity workforce needs now and in the long term.

Maternity services are important in so many ways, it is vital that we get them right. A new maternity strategy is the best way to ensure the development of services that are responsive and evidence-based and provide safe, sustainable, quality care to women and their families.

The Minister of Health should progress work on a new maternity strategy for Northern Ireland without delay.

To inform that process we must see the immediate publication of the end-of-strategy report that has been with the Minister's department since summer 2020. The Minister of Health should immediately place that report in the public domain. We need to see it and start the work of learning what needs to happen next.

Fundamental to how we develop any strategy is recognising the need for transformational change that ensures women are at the centre of the system, not trying to navigate a system that does not match their needs.

Women and their families deserve a service that reflects the needs of the population, challenges health inequalities and ensures that Northern Ireland's next generation is healthier than any that has come before.

Let's start that work without delay. ■

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