

Consultation on the development of a National Maternity Strategy

A report prepared for the Department of Health by the Institute of Public Health in Ireland



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Glossary

ADCNME	Association of Directors of the Centres of Nursing and Midwifery Education
ALCI	Association of Lactation Consultants in Ireland
AML	Active Management of Labour refers to the approach to the prevention of a prolonged labour (defined as 12 hours or more)
AIMS Ireland	Association for the Improvement of Maternity Services in Ireland
Amniocentesis	Amniocentesis is a procedure used to diagnose foetal defects at a certain stage of pregnancy. A sample of the amniotic fluid, which surrounds a foetus in the womb, is collected. Tests performed on foetal cells found in the sample can reveal the presence of many types of genetic disorders, thus allowing doctors and prospective parents to make decisions about early treatment and intervention.
Antenatal	The period from conception until labour begins
ASH Ireland	Action on Smoking and Health Ireland
BFLGI	Baby Feeding Law Group Ireland
BFHI	Baby Friendly Hospital Initiative. BFHI was launched by WHO and UNICEF in 1991 as a global effort to implement practices that protect, promote and support breastfeeding. The implementation of the initiative focuses on services adopting 'ten steps to successful breastfeeding'.
CEO	Chief Executive Officer
CMM	Clinical Midwife Manager
CPD	Continuous Professional Development
CVS	Chorionic Villus Sampling is a test that can detect genetic and chromosomal abnormalities in an unborn baby. Chorionic villus sampling is performed on pregnant women who are at risk of carrying a foetus with a genetic or chromosomal defect.
DoH	Department of Health
Domino Scheme	Domiciliary Care In and Out of Hospital. A system of care delivery that is led by community midwives and facilitates principally home-based antenatal, intrapartum and postnatal care including continuity of care with an assigned midwife and early hospital discharge after birth. It is only available in some areas.
Doula	A doula is a nonmedical person who assists a woman before, during, and/or after childbirth, as well as her family, by providing physical assistance and emotional support.
Early Transfer Scheme	A service which supports mothers to leave hospital from 12 hours after the birth of their baby through the provision of a team of midwives providing postnatal care, support and advice at home.
Eighth Amendment	The eighth amendment to the Irish Constitution relates to a constitutional ban on abortion.
Episiotomy	A surgical cut of the perineum (the area between the vagina and anus) and the posterior vaginal wall performed during labour.
Ethnic identifier	A field included on health information systems which identifies the ethnic group of that service user, based on their voluntary

FAS	self-report of their identity and according to set categories. Foetal Alcohol Syndrome is a syndrome occurring in infants which is caused by alcohol use in pregnancy and is associated with damage to the central nervous system. FAS is one manifestation of FASD and is included in the International Classification of Diseases (ICD-10).
FASD	Foetal Alcohol Spectrum Disorder is an umbrella term relating to a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These may include physical, behavioural and/or sensory/learning disabilities.
First 1000 Days Campaign	The First 1000 Days Campaign began as a UNICEF led campaign to promote optimal nutrition for mothers and infants and prioritise child development by enhancing the nutrition of women in pregnancy and for infants in their early years. In recent years in Ireland, the term ‘first 1000 days’ has become synonymous with a commercially funded campaign in Ireland.
FOI	Freedom of Information
GA	General Anaesthetic
Gestational diabetes	A condition in which women without previously diagnosed diabetes exhibit a raised blood glucose level during pregnancy. These raised blood glucose levels can affect maternal, foetal and infant health outcomes.
GP	General Practitioner
HIPE Data	Hospital In-Patient Enquiry Data
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
Hub and Spoke Model	In the context of the consultation responses this model of care generally refers to the links and transfer of expertise between larger (the ‘Hub’) and smaller units (the ‘spokes’).
INDI	Irish Nutrition and Dietetic Institute
Intrapartum	During labour (from the start of labour to the delivery of the placenta)
IMEWS	Irish Maternity Early Warning System
Maternity and Infant Care Scheme	An agreed minimum programme of shared antenatal and postnatal maternity care supplied free of charge to all expectant mothers who are ordinarily resident in Ireland. This service is provided by a family doctor (GP) of choice and a hospital obstetrician/midwife.
MINDI	Member of the Irish Nutrition and Dietetics Institute
MLU	Midwifery Led Unit
NCEC	National Clinical Effectiveness Committee. A ministerially appointed committee established to prioritise and quality assure National Clinical Guidelines and National Clinical Audit.
NGO	Non-Governmental Organisation
NICE	National Institute for Health and Care Excellence (UK)
NICU	Neonatal Intensive Care Unit
NMPDU	National Midwifery Planning and Development Units
NMH	National Maternity Hospital
NRP	Neonatal Resuscitation Programme
NPRS	National Perinatal Reporting System

NUIG	National University of Ireland Galway
NWCI	National Women’s Council of Ireland
OECD	The Organization for Economic Cooperation and Development (OECD) is a grouping of 34 countries which have signed the Convention on the Organisation for Economic Co-operation and Development.
Outreach clinic	A health care facility usually operated under the auspices of a large institution but situated in a location some distance from the larger health centre.
PEWS	Paediatric Early Warning System
PHN	Public Health Nurse
Postnatal	The period from after giving birth
Postpartum	After birth has occurred
PPD	Postpartum Depression
PPPGs	Policies, Procedures Protocols and Guidelines
PPSN	Personal Public Service Number
Preconception	Before pregnancy occurs
PTSD	Post-traumatic stress disorder (PTSD) is a mental health condition triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.
RCSI	Royal College of Surgeons Ireland
RCPI	Royal College of Physicians in Ireland
Sepsis	An inflammatory condition resulting from the spread of bacteria or their toxins from a focus of infection which can result in tissue damage, organ failure and death.
Social inclusion	Actions which promote the inclusion of vulnerable or marginalised individuals and groups in society supporting them to realise their rights, access services and supports relevant to their needs and participate fully as valued members of the wider community.
Tongue-tie	A defect in the development of the baby’s mouth that occurs while in the womb and is present at birth and which may affect the functional mobility of the tongue in the context of feeding.
UCD	University College Dublin
UK	United Kingdom
UNICEF	United Nations Children’s Fund
VBAC	Vaginal Birth After Caesarean
Vision for Change	A Vision for Change is a government strategy document which sets out the direction for mental health services in Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.
WHA	World Health Assembly
WHO	World Health Organization
WHO International Code of Marketing of Breastmilk Substitutes	An international health policy framework for breastfeeding promotion adopted by the World Health Assembly (WHA) of the World Health Organization (WHO) in 1981. The Code

includes restrictions on the marketing of breastmilk substitutes, such as infant formula.

Executive Summary

Introduction

The Department of Health is currently developing a National Maternity Strategy. The primary aim of the strategy is to ensure that women in Ireland have access to safe, high quality maternity care in a setting most appropriate to their needs. In June 2015 the DoH initiated an online public consultation. The Institute of Public Health in Ireland analysed the consultation data and produced a report detailing the main findings. These findings will be used to inform the development of the new National Maternity Strategy.

Engagement and interpretation

The process captured a wide range of both individual and organisational perspectives on maternity services in Ireland, with 1324 responses (comprising 73 organisations, 202 health care professional, 1019 service users and 30 ‘others’) and over 450,000 words of text. In addition, the Department of Health organised and reported on two focus groups.

Responses were systematically analysed using appropriate quantitative and qualitative methodologies, with due attention to data protection and confidentiality. The consultation report highlights common themes relevant to the development of policy rather than a complete representation of individual views.

Meaningful comparison with national figures (National Perinatal Reporting System, NPRS) is limited by different methods of data collection but the distribution of service user responses was broadly similar to the national distribution of births occurring over that period in terms of geographic distribution. However, comparison with the national figures suggests that mothers who experienced a home birth were significantly over represented in the consultation sample. Data from the NPRS also shows that 0.2% of all births in 2013 took place at home. This is compared to 11.5% of the consultation respondents. The sample of views analysed cannot be considered as nationally representative of public opinion as consultation processes, by their nature, collect the views of interested stakeholders.

Service users’ reports on their antenatal, intrapartum and postnatal care setting

Reported setting that care was received

There were a wide variety of maternity service options used by service user respondents in respect of antenatal, intrapartum and postnatal care. Hospitals formed a component of

antenatal and intrapartum care for eight out of ten pregnancies among the consultation respondents, and most postnatal care was distributed between hospital, community and home.

Views on the most appropriate setting for each stage of care

There was a strong preference for community based care or combined care between the hospital, community and home setting.

Views of Current Irish Maternity Services

Rating of maternity services

There was a level of concern among respondents in respect of many domains of maternity services. In particular respondents were most likely to rate the provision of information and choice in services as poor. A third of respondents considered that maternity services were performing poorly in terms of providing advice on healthy lifestyles. One quarter of respondents rated services poorly in terms of quality and in terms of safety.

Aspects of the service that are working well

The following aspects of current maternity services were identified by respondents (n=1324) as working well:

- The professionalism and dedication of frontline staff.
- Midwifery-led care and community midwives/dominant and early discharge scheme.
- Home birth services.
- Access to free care under the *Maternity and Infant Care Scheme*.
- Hospital consultant led services particularly in the context of complex pregnancies and effective management of emergencies.
- Combined care (hospital and GP) during pregnancy.
- Access to allied specialist support services (dietician, physiotherapy and community mental health services).

Aspect of the services that are not working well

The most common aspects of maternity services identified by respondents as not working well were:

- Poor breastfeeding support in the hospital and community setting.

- Limited care options and a lack of choice.
- Over-medicalised model of childbirth for low risk women.
- Overcrowding and a lack of resources and staff.
- Inadequate engagement with women as partners in their care.
- Poor staff communication.
- Excessive antenatal clinic waiting times.
- Poor quality and inconsistent antenatal and postnatal care, support and advice.
- Limited mental health supports in the community.
- Unsatisfactory care following a loss or bereavement.

Priorities for the Improvement of Maternity Services

Table 1 displays the most commonly identified priorities for the improvement of services.

Table 1: *Priorities for the Improvement of Maternity Services*

	1st	2nd	3rd
Advice and care on getting pregnant	Health and wellbeing information	Raise folic acid awareness	Establish formalised preconception services/ guidelines
Care during pregnancy (antenatal)	Expand community based antenatal care services	Reduce waiting times in antenatal clinics	Equal and more frequent access to scans
Care during labour (intrapartum)	Offer more options	Reduce medical intervention/ normalise	Address staffing levels
Care for mothers following the baby's birth (postnatal)	Enhance breastfeeding support	Enhance postnatal care in the home/ community	Enhance services for mothers postnatal physical health
Care for baby following the birth (postnatal)	Enhance breastfeeding support	Increase number of PHN visits	Invest in community midwifery led postnatal care
Care following a loss	Improve staff sensitivity and support	Create separate hospital facilities/space	Enhance counselling services

Suggestions for Service Provision

The consultation document posed a number of questions relating to different aspects of service provision. The key issues raised under each aspect are outlined below.

- Promote health and wellbeing by standardising advice to mothers during the preconception and antenatal period across all settings. Initiate broader public health campaigns that highlight the benefits of health and wellbeing for women and their babies.
- Provide information on care options that is clear, consistent/standardised and unbiased. Make clear the benefits, risks and alternatives for each model of care and publish statistics on hospital intervention rates, safety records, complaints and staff-patient ratios.
- Facilitate a choice of care models through the expansion and integration of community and home birth services. Design and deliver services on the basis of international best practice and a strong evidence base.
- Ensure safety by addressing staffing levels and adequately resource and invest in maternity services. Facilitate transparency and accountability through clear governance structures, accessible hospital data, and routine audits, inspections and reviews.
- Make services needs centred by integrating structured feedback mechanisms and service user consultation as part of the planning of all aspects of the service.
- Facilitate access to services by integrating large and smaller hospital units and increase the number of outreach clinics. Establish and standardise referral pathways between hospitals (small and large units) and between the community and hospital setting.

Suggestions for Workforce and Governance

A number of key issues were frequently highlighted in regard to workforce and governance, this includes:

- Incentivise training and continued professional development.
- Provide supportive and encouraging staff performance reviews/appraisals as a method to increase the capacity and potential of staff.

- Promote a healthy work environment that encourages a collaborative/ interdisciplinary approach to work and an atmosphere that is non-hierarchical.
- In the context of multidisciplinary team work, ensure that roles are clearly defined, provide interdisciplinary training programmes and develop an electronic notes/record system.
- Define a system of consistent and regular audit, reviews and inspections to ensure that best practice is consistently applied across all aspects of the service.
- Define clear governance structures to ensure accountability and transparency.

Summary Cross Cutting Themes

There are a number of key issues that were frequently raised across all aspects of the consultation. Therefore it is possible to highlight areas where there was a great deal of consensus among consultation respondents which would form priority cross-cutting issues in the development of the National Maternity Strategy.

High level service planning:

- Facilitate choice of care (hospital, community, home) and make options available to service users regardless of their geographical location or ability to pay.
- Increase the capacity of midwifery led services for women categorised as a low risk. Expand access to the Domino Scheme, Early Transfer Schemes and Home Birth Services. Establish more Midwifery Led Hospital Units. Integrate home birth services with hospital services.
- Enable smooth transition of care between services through a centralised electronic service user record.
- Reduce antenatal clinic waiting times by improving the appointment system and increasing the capacity of midwifery clinics and/or outreach clinics.
- Promote the benefits of health and wellbeing for women and their babies through online campaigns and information services. Establish standardised preconception and antenatal health and wellbeing guidelines.
- Invest in and develop postnatal services in the hospital, community and home setting.
- Implement the HSE Breastfeeding Action Plan and the Baby Friendly Hospital Initiative.

High level service quality and safety:

- Maintain adequate levels of staffing and resources. Implement workforce planning following an appropriate needs assessment. Relieve pressure on hospitals by providing more care in the community.
- Ensure continuity of care between healthcare settings and across healthcare professionals. Facilitate where possible access to the same healthcare provider at each stage of care.
- Develop and implement evidence based standardised maternity care guidelines (e.g. NICE).
- Improve communication skills of HCP and improve mechanisms for multidisciplinary team work.
- Audit, review and ensure transparency. Publish statistics on maternity care for all settings and provide information on hospital guidelines to service users.
- Improve postnatal care in the community and hospital settings by increasing the capacity of GPs and PHNs.

Management of labour:

- Provide women-centred care and ensure that women's needs and wishes are listened to and that they are afforded dignity and respect through all stages of their intrapartum care.
- Provide the option of a natural birth by reducing the number of medical interventions in the hospital setting. Facilitate informed consent and shared decision making at all stage of intrapartum care.

Support services:

- Provide more and better quality breastfeeding support in the hospital, community and home setting. Support should include information and advice during the antenatal period, access to lactation consultants, tongue tie checks at hospital discharge, training for PHNs on providing breastfeeding support, reduce infant formula top ups and increase staff on postnatal wards.
- Integrate mental health and wellbeing support services across all elements of maternity services.
- Establish hospital bereavement teams and implement the forthcoming HSE bereavement care standards.

Section 1: Introduction

1.1: Policy Context

The Department of Health is currently developing a National Maternity Strategy. The primary aim of the strategy is to ensure that women in Ireland have access to safe, high quality maternity care in a setting most appropriate to their needs. In April 2015, the Minister for Health established a Steering Group to advise on the development of the strategy. The aim of the steering group is to develop a National Maternity Strategy which encompasses preconception, antenatal, intrapartum, postnatal and neonatal care provided across acute, primary and community settings.¹ The terms of reference of the Steering Group exclude assisted human reproduction.

According to the Steering Group's Terms of Reference, the strategy will be based on the following themes:

- A Health and Wellbeing approach is adopted to ensure that babies get the best start in life. Mothers and families are supported and empowered to improve their own health and wellbeing;
- Women have access to safe, high quality, nationally consistent, woman-centred maternity care;
- Pregnancy and birth is recognised as a normal physiological process, and insofar as it is safe to do so, a woman's choice is facilitated;
- Maternity services are appropriately resourced, underpinned by strong and effective leadership, management and governance arrangements, and delivered by a skilled and competent workforce, in partnership with women.

In doing so, the Steering Group aims to address the following key issues:

- a) Principles which should underpin integrated models of care and appropriate care pathways.
- b) Arrangements for workforce planning and organisation which maximise the contribution of the maternity service workforce, support the delivery of best practice models of care and facilitate staff to work to the full scope of their practice; and,

¹ Generally spanning the period from up to three months before conception until six weeks after birth.

- c) Governance and leadership arrangements necessary at a local, regional (hospital group) and national level to ensure the outcomes set out at (a) above are achieved and demonstrated.²

To inform their work, the steering group initiated a public consultation via the Acute Hospitals Division at the Department of Health in June 2015.

1.2: Consultation Process

A public consultation process was opened on the 18th of June 2015 and closed at 5pm on the 15th of July 2015.

Consultation responses were invited based upon an online questionnaire using Survey Monkey. The questionnaire was made available on the Department of Health website.

The Institute of Public Health in Ireland was engaged to develop a consultation report based on the 1324 valid submissions received.

In conjunction with the online questionnaire, two focus groups facilitated by the Department of Health were held in July 2015. The data from this strand of the consultation were analysed and reported on by the Department of Health. The main findings from this strand of the consultation can be found in section 4.

1.3: Data Handling and Analysis

Submissions received by the Department are subject to the Freedom of Information (FOI) Act and may be released in response to a FOI request. The Department publishes responses to FOI requests online. More information on FOI is available on www.health.gov.ie.

Personally identifiable information supplied by a respondent to the Department is held in accordance with the Data Protection Act 1988, and the Data Protection Amendment Act, 2003. The Department keeps it only for explicit and legitimate purposes, processes it only in ways compatible with the purposes for which it was given and keeps it safe and secure, retaining it no longer than is necessary.

A data handling protocol was devised and agreed between the Institute of Public Health in Ireland and the Department of Health in respect of the submissions received.

² See <http://health.gov.ie/wp-content/uploads/2015/01/National-Maternity-Strategy-for-website.pdf>

The submissions contained both quantitative data and free text responses suitable for qualitative analysis. Quantitative data were analysed using SPSS version 22 data analysis software. The quantitative data were analysed to produce frequencies in respect of various aspects of the responses. Approximately 450,000 words of free-text were received as responses to open-ended consultation questions. Data were approached using qualitative data analysis techniques based upon a thematic approach. Responses to each question were read and re-read to identify codes (a code describes segments of text with similar meaning). These codes were then systematically applied to each response. Responses under these codes were then examined for consistency. Where response codes emerged as similar these were merged to form broader codes and where responses did not fit into existing codes new codes were formed. This process was repeated for each question (Denscombe, 2007).

The following chapters present the findings of the quantitative and qualitative analyses undertaken. With regard to the qualitative analysis, quotes are used to illustrate the viewpoints of consultation respondents relevant to the themes presented. These quotes have been anonymised to the category of the respondent and therefore omit the individuals or organisations name. The quotes use the exact text submitted by that respondent and as such reflect as far as possible the exact format, grammar and spellings used by that respondent. In some responses, published and unpublished research was presented as evidence to support certain viewpoints. That evidence has been referred to only in general terms and no appraisal of the quality of such evidence has been made in this report. References to specific hospitals or services were omitted.

Section 2: Overview of Consultation Responses

2.1: Interpretation of Consultation Content

This report has been prepared by the Institute of Public Health in Ireland for the Department of Health to present key findings from the responses received in the context of the consultation on the forthcoming National Maternity Strategy. Consultation processes do not provide representative samples of public opinion; instead they seek information, comments and views on the consultation questions from interested stakeholders. The nature of consultation exercises means that respondents are self-selecting and cannot therefore be considered a representative sample of public opinion.

2.2: Number and Type of Respondents

In total there were 1324 valid responses. Responses were only included if the respondent agreed to the following: ‘All submissions received by the Department are subject to the Freedom of Information (FOI) Act, 2014 and may be released in response to an FOI request. The Department publishes responses to FOI requests online’. Only a small number of consultation questions were compulsory, therefore the valid number of respondents for each question varies throughout the report.

2.2.1: All Responses

Table 2 shows that most submitted a response based on their own personal experience (n=1019) and a further 202 responses were based on their experience as a healthcare provider. Appendix B presents the list of individuals who consented to their name being included as a contributor (n=779). In total, 73 organisations submitted a response³ and appendix A presents a list of these organisations. Thirty respondents selected ‘other’.

³ In the initial analysis of the data, 81 respondents stated they were responding of behalf of an organisation. On closer inspection of these cases it was clear that a small number were responding based on their experiences as a service user (n=4) or as a healthcare professional (n=4). These responses were then recoded into the appropriate category.

Table 2: Overview of Respondents

	Frequency	%
Type of Response		
Based on personal experience	1019	77
Based on experience as a healthcare provider	202	15.3
On behalf of an organisation	73	5.5
Other	30	2.3
Total	1324	100

2.2.2: Organisational Responses

Table 3 outlines the type of organisations that responded to the consultation. Almost 18% of respondents' stated their organisation was a healthcare professional/worker body (n=13). A similar proportion of respondents categorised their organisation as a healthcare professional/worker representative organisation (16.4%, n=12) or a maternity care services provider (17.8% n=13). Five respondents submitted on behalf of an academic institution. The category 'Organisation' includes NGOs, semi-state bodies or other interest groups and amounted to 24.8% (n=18) of all organisational responses.

Table 3: Type of Organisation

	Frequency	%
Service user representative body	7	9.6
Maternity care service provider	13	17.8
Healthcare professional/worker body	13	17.8
Healthcare professional/worker representative organisation	12	16.4
Academic Institution	5	6.8
Organisation	18	24.8
Other	5	6.8
Total	73	100

2.2.3: Type of Healthcare Worker/ Professional

Table 4 presents the type of healthcare workers/ professionals who responded to the consultation. Over half of healthcare workers/ professionals who responded self-categorised as midwives (58.8%, n=117). This category included hospital midwives, midwifery managers, midwifery academics, student midwives and community midwives. In total twenty two doctors responded to the consultation including specialists in obstetrics, general practice, neonatology, paediatrics, anaesthetics and psychiatry. Nine lactation consultants submitted a response. The remainder of HCP respondents represented a wide variety of professions including anaesthetist, physiotherapists, sonographer, social workers, neonatologist, and nurses. The 'other' category (n=16) includes professionals such as chaplain, counsellors,

hospital pharmacists, health and safety officers, learning specialist, bereavement care project manager, health care professional working on a Risk Assessment Management Programme (RAMP) for diabetes, speech and language therapist and a smoking cessation coordinator.⁴

Table 4: Type of Healthcare Worker/ Professionals

	Frequency	%
Midwife ^a	117	58.8
Other	16	8.0
Lactation Consultant	9	4.5
Obstetrician	8	4.0
Doctor (other)	7	3.5
Dietician	5	2.5
Nurse	5	2.5
Complementary practitioner ^b	4	2.5
Psychologist / Clinical Psychologist	4	2.1
Academic	4	2.1
Anaesthetist	3	1.5
Physiotherapist	3	1.5
Social Worker	3	1.5
Hospital Manager	3	1.5
GP	2	1.0
Neonatologist	2	1.0
Other Manager/ director of services	2	1.0
Ultra sonographer	1	0.5
Total	198 ^c	100

^aThis category included hospital midwives, midwifery managers, midwifery academics, student midwives and community midwives ^bThis category includes birth doulas, homeopath, and a pregnancy yoga teacher. ^c Information missing for those re-categorised from organisational respondents to health care professionals (n=4) (see footnote 4).

⁴ Initially, 68 respondents selected the ‘other’ category but most were recoded into existing categories.

Section 3: Online Consultation Findings

3.1: Overview

The consultation questionnaire comprised thirty seven questions. This section summarises the key findings emerging from the responses to those questions. Outputs from analysis of the responses are presented under each consultation question according to a standardised format. For clarity and ease of reference, the exact wording and response parameters of each consultation question are first presented. Then the number and nature of consultation responses are presented. This is followed by an overview of key themes raised in respect of current and future maternity services in Ireland under each consultation question.

3.2: Respondents' Experiences of Irish Maternity Services

3.2.1: Profile of Maternity Service User Respondents

In total 1011 respondents (or their partners) provided information on their experience of Irish maternity services.⁵ For most respondents their experience with Irish maternity services occurred in the past 5 years (89.2%, n=901). Table 5 also shows that three quarters of respondents accessed public services (74%, n=768).

Table 5: Profile of Respondents who have used Irish Maternity Services

	Frequency	%
Decade of birth		
2010- present	902	89.2
2000-2009	98	9.7
1990-1999	9	0.9
Prior to 1990	2	0.2
Type of Service		
Public	768	76
Private	242	24
Total	1011	100

Table 6 presents a breakdown of service user respondent by county of residence at the time of the birth. Around half of consultation respondents had accessed services in Dublin (39%, n=394) or Cork (10.3%, n=104). The county of residence of the mother at the time of giving birth of consultation respondents was compared with the national picture (NPRS data for 2013). Meaningful interpretation is very limited by the different methods used to collect the

⁵ In total 4 respondents had never used Irish maternity services. The remaining 4 missing cases are those re-categorised from organisational respondents to service user respondents.

data and the different years of birth included in the consultation respondents. However, this simplistic overview suggests that the views and experiences of families from a wide geographic distribution were captured in the consultation response. It is also apparent that the views and experiences of families living in the Dublin area and surrounding counties of Kildare and Wicklow may be somewhat overrepresented and, conversely, the views of families living in rural counties, such as Donegal, Mayo, Sligo, Cavan, Leitrim, Mayo, Tipperary and Kerry, may be somewhat underrepresented. Small numbers in the consultation response relative to the national sample are also a significant consideration in the interpretation of distribution of births by county.

Table 6: County of Residency at Time of Birth

	Frequency	Consultation figures %	National Figures (NPRS, 2013) %
Armagh (NI)	1	0.1	0
Carlow	12	1.2	1.3
Cavan	8	0.8	1.6
Clare	26	2.6	2.1
Cork	104	10.3	11.4
Donegal	8	0.8	2.8
Dublin	394	39.0	29.6
Galway	52	5.1	5.4
Kerry	10	1.0	2.5
Kildare	64	6.3	5.0
Kilkenny	13	1.3	1.9
Laois	23	2.3	1.8
Leitrim	3	0.3	0.7
Limerick	32	3.2	4.1
Longford	7	0.7	0.9
Louth	22	2.2	2.9
Mayo	13	1.3	2.4
Meath	41	4.1	4.5
Monaghan	11	1.1	1.2
Offaly	14	1.4	1.5
Roscommon	12	1.2	1.2
Sligo	7	0.7	1.3
Tipperary	22	2.2	3.3
Waterford	24	2.4	2.5
Westmeath	17	1.7	1.9
Wexford	20	2.0	3.0
Wicklow	51	5.0	3.0
Total	1011	100	100

3.2.2: *Type of Maternity Care Setting*

Individuals who were submitting a response based on their own experience (n=1011) were asked in which setting they received their care for different stages of the pregnancy. The wording of the question is as follows:

Q. 14: In what setting were the following types of care provided for that same pregnancy?

- a) Advice and care on getting pregnant (up to 3 months before conception).
- b) Care during pregnancy (antenatal care).
- c) Care during labour (intrapartum care).
- d) Care following baby's birth (up to 6 weeks after birth).
- e) Care for those who have experienced a loss.

For each of the above respondents could choose the following options: a) hospital, b) community, c) home, d) other, e) not applicable.

This was a multiple response question whereby respondents could select more than one setting for each stage of care. These responses were then recoded into the categories presented in Table 7 which captures whether the services user had individual or combined care arrangements. Respondents could also select 'not applicable' if they did not access services at a particular stage of care.

a) Advice and care on getting pregnant (up to 3 months before conception)

For the majority of respondents (66.5%), the setting for preconception care was 'not applicable'. This indicates that for two thirds of respondents they did not access services prior to becoming pregnant. The community and 'other' were the most common settings for those that did access preconception services. 'Other' in most cases referred to GP services for those that did not view this as part of community care. A small number of respondents stated that they received preconception care in the home (n=69) or in the hospital setting (n=41). A small number of respondents stated that they accessed fertility services.

b) Care during pregnancy (antenatal care)

Many respondents stated that they received antenatal care in the hospital setting only (38.9%, n=394) or combined care between the hospital and community setting (i.e. GP services) (29%, n=293). Just over 6% stated that they received their antenatal care in the home only. These figures are compared with the national figures in the next section.

c) Care during labour (intrapartum care)

The majority of respondents stated that they received care during labour in the hospital setting (77.2%, n=778). The next most common response was intrapartum care – home only which was interpreted as a home birth (11.5%, n=116). The remaining respondents stated that they received another combination of care such as hospital and home (n=31) or hospital and community (n=27). The national figures on home births are compared with the consultation responses in the next section.

d) Care following baby's birth (up to 6 weeks after birth)

Table 7 illustrates that a wide variety of care models were utilised by respondents during the postnatal period. For many respondents they received their postnatal care in the home (17.9%, n=180) or the community (26.9%, n=271) including GPs, PHNs, and/or community midwives. In total, 15% of respondents received follow up care in both the hospital and community setting. The remaining respondents stated that they received their care in some combined form between hospital, community and/ or the home setting.

e) Care for those who have experienced a loss

Over 15% (n=144) of respondents indicated that they accessed services following a loss. In total, 84 respondents indicated that they received care following a loss in the hospital setting only. Relatively few respondents received follow up care/ support in the community or home. Indeed, a number of respondents indicated in the 'other' text box that they received little or no follow up care whatsoever after experiencing a loss.

Table 7: Type of Care by Setting

	Advice and care on getting pregnant		Care during pregnancy		Care during labour		Care following the baby's birth		Care following a loss	
	N	%	N	%	N	%	N	%	N	%
Not applicable	646	66.5	3	0.3	26	2.9	28	2.9	774	84.3
Hospital Only	41	4.2	394	38.9	778	77.2	91	9.0	84	9.2
Community only	67	6.9	91	9.0	5	0.5	271	26.9	8	0.9
Home only	69	7.1	62	6.2	116	11.5	180	17.9	6	0.7
Other	115	11.8	24	2.4	5	0.5	28	2.8	23	2.5
Hospital, community & home	2	0.2	32	3.1	2	0.2	94	9.3	2	0.2
Hospital & community	13	1.3	293	29.0	27	2.7	151	15.0	9	1.0
Hospital & home	0	0	31	3.1	31	3.1	39	3.9	3	0.3
Home & community	1	0.1	16	1.6	4	0.4	86	8.6	0	0
Other combination of care	18	1.9	64	6.3	14	1.4	37	3.9	9	1.0
Total valid	972	100	1010	100	1008	100	1005	100	918	100
No answer provided	39		1		3		6		83	

3.2.3: Comparison of Care Type with the National Picture

The distribution of type of antenatal care was compared between the consultation respondents and nationally representative data collected through the NPRS for the most recent year available (births in 2013). Meaningful comparison is significantly limited by the different categories used to classify the service type as well as the different methods used to collect the information between the two samples. Consequently, comparisons are only made for those who stated that they received their antenatal care in the hospital setting only. The NPRS data shows that 20.5% received care during their pregnancy (antenatal care) in the hospital. This is compared to 38.9% of consultation respondents and therefore suggests the experience of families using hospital only care may be somewhat overrepresented in the consultation response compared to the national picture.

In addition, the proportion of births that could be considered home births was compared between the consultation respondents and nationally representative data collected through the NPRS using the most recent year available (births in 2013). Again, meaningful comparison is limited by differences in the collection of the information. According to NPRS data, 0.2% of all births in 2013 were classified as ‘domiciliary’ or home births. This is compared to 11.5% of consultation respondents who stated that their home was the only setting they received care during labour and a further 4.5% stated that the home formed some part of their intrapartum care. This would indicate that the views and experiences of mothers who had experienced a home birth are significantly overrepresented in the consultation response compared to the national picture.

It has already been emphasised that consultation responses are not designed to capture a nationally representative sample. However, understanding the differences between consultation respondents and the national picture can be important in interpretation of the consultation response for policy purposes.

3.3: Respondents’ Views on Irish Maternity Services

The next section of the consultation sought to gather respondents’ views of Irish maternity services. This section was open to all respondents and includes services users, healthcare professionals and organisations (n=1324).

3.3.1: Respondents’ Rating of Maternity Services

Question 15 was a multiple choice question asking respondents to rate each aspect of maternity services outlined below on a five point scale from ‘very good’ to ‘very poor’.

Q. 15: How would you rate maternity services in Ireland under the following headings, based on your own experiences?

- a) Advice on a healthy lifestyle (benefits for mothers & babies)
- b) Information on services
- c) Choice of services
- d) Safety
- e) Quality of Care

For each of the above respondents could choose from the following options: a) very good, b) good, c) acceptable, d) poor, e) very poor

Figure 1 presents an overview of the distribution of responses from question 15. Table 10 below gives a detailed breakdown of the results. In addition to frequency analysis of question 15, bi-variate tests of significance (Chi-square) were conducted to assess whether views on services differed by type of respondents (i.e. service user, healthcare professionals or organisations). To check whether views of services differ by geographical location, counties were recoded using the NUTS 3 Region eight category classification as cell numbers were too small to carry out bi-variate analysis using county breakdown.⁶

Figure 1: Respondents' Rating of Irish Maternity Services

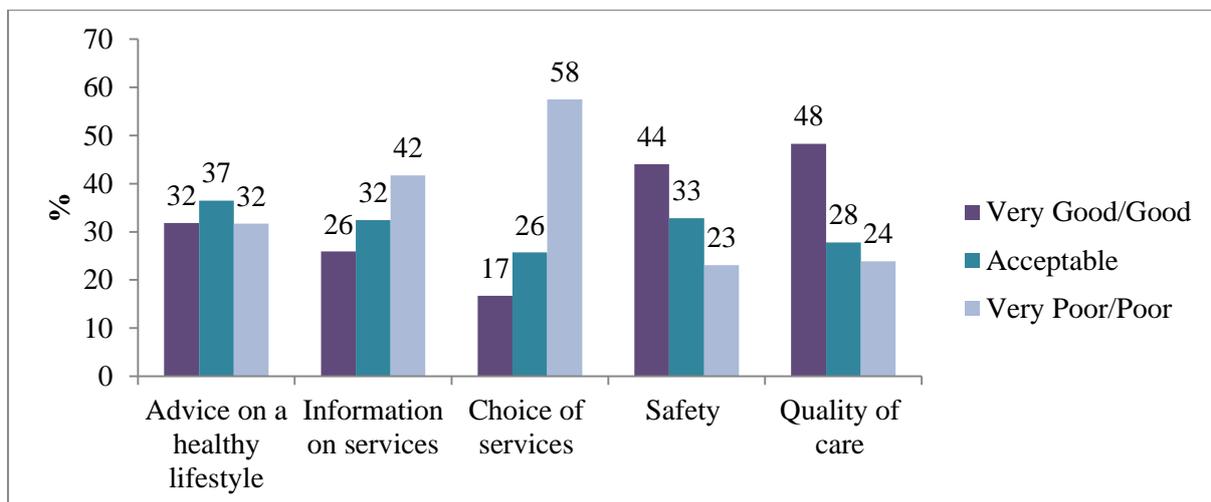


Table 8: Respondents' Views of Maternity Services

⁶ 'The Nomenclature of Territorial Units for Statistics (NUTS) were drawn up by Eurostat in order to define territorial units for the production of regional statistics across the European Union. The Irish NUTS 3 regions comprise the eight Regional Authorities established under the Local Government Act, 1991 (Regional Authorities) (Establishment) and are as follows: Border, West, Midlands, Mideast, Midwest, Dublin, Southeast, Southwest.' source: <http://www.cso.ie/en/census/census2011boundaryfiles/>

	Very Good	Good	Acceptable	Poor	Very Poor
	% (n)	% (n)	% (n)	% (n)	% (n)
Advice on a healthy lifestyle	7.6 (100)	24.2 (320)	36.5 (482)	24.1 (319)	7.6 (100)
Information on services	5.4 (71)	20.5 (271)	32.4 (429)	31.2 (411)	10.5 (139)
Choice of services	4.3 (57)	12.4 (163)	25.7 (339)	36 (474)	21.5 (282)
Safety	13.5 (177)	30.5 (399)	32.8 (431)	16.5 (215)	6.6 (87)
Quality of care	17.3 (227)	31 (407)	27.8 (366)	17.4 (228)	6.5 (86)

Advice healthy lifestyle (missing=4), information on services (missing=4), choice of services (missing=10), safety (missing=16), quality of care (missing=10).

a) Advice on a healthy lifestyle

With regard to advice on a healthy lifestyle, 32% stated that this aspect of the maternity service was ‘very good’ or ‘good’, and a further 36.5% rated it as ‘acceptable’. Almost a third stated that advice on a healthy lifestyle in current service provision was ‘very poor’ or ‘poor’. There were no significant differences in views of services by type of respondents (i.e. services user, HCP or organisation) or by geographical location.

b) Information on services

Information on services was rated less favourably as 42% stated that this aspect of current services as ‘poor’ or ‘very poor’. Just a quarter of respondents rated it as ‘good’ or ‘very good’. There were no significant differences in views of services by type of respondents (i.e. services user, HCP or organisation) or by geographical location.

c) Choice of services

Only 17% of respondents gave a rating of ‘very good’ or ‘good’ for choice of services, whereas almost 60% viewed the choice of services as ‘poor’ or ‘very poor’. There were no significant differences in views of services by type of respondents (i.e. services user, HCP or organisation) or by geographical location.

d) Safety

In total, 44% of respondents’ rated safety as ‘very good’ or ‘good’ and a further 33% rated safety aspects as ‘acceptable’. Almost a quarter stated that safety in their view of maternity services was ‘poor’ or ‘very poor’. There were no significant differences in views of services by type of respondents (i.e. services user, HCP or organisation) or by geographical location.

e) Quality of Care

In total, 23.9% reported that the quality of care was ‘poor’ or ‘very poor’, with many stating it was ‘very good’ or ‘good’ (48.3%) or acceptable (27.8%). There were no significant differences in views of services by type of respondents (i.e. services user, HCP or organisation) or by geographical location.

3.3.2: Respondents’ Views of Maternity Services

Q. 16: In your view, what is working well in Ireland’s maternity services?

All 1324 valid respondents provided an answer to question 16 resulting in 39,628 words of text. These responses were analysed using a thematic framework approach. The main aspects of maternity services identified as working well are as follows and are outlined in more detail below:

- Dedicated, hardworking staff.
- Midwifery led care.
- Home birth care.
- Consultant care for complex or high risk cases.
- Positive experiences with antenatal or postnatal care services.
- Accessible, free care.
- Positive experiences of specialised services.

a) Dedicated frontline staff

The main theme to emerge from the text analysis of question 16 is the dedication of frontline staff that provide care to families and their babies.

There are many aspects of our current maternity service working well and this is due to the dedicated, caring and knowledgeable healthcare workers providing excellent care to women and their families (Service user).

Most frequently, respondents referred to the professionalism and hard work of midwives. This respondent suggested that despite working in unfavourable working conditions their midwifery care made them feel safe and cared for at all times.

In my view the single most important asset to the maternity service in Ireland is their midwives. They are stretched so thinly but somehow maintain a level a care and

professionalism that you have to commend. I could see how tight the midwives were at times I had only a student looking after me but somehow they managed to make me feel safe and that everything was under control. It was my first birth and it was really quite a traumatic birth and o honestly don't think I would have gotten through it without them. I felt like they had my back and all would be ok in the end (Service user)

The theme of providing good quality care in the context of staff shortages and a lack of resources was also highlighted by healthcare professionals.

Your doctors and midwives are your greatest asset. These are some of the best, brightest, most experienced and most resilient people I have ever had the privilege to work with, and the ONLY reason the maternity services of Ireland have not collapsed is because they are stemming the tide they sacrifice their lives quite literally, working anywhere between 80-100 hours each week in back breaking 30 hour shifts that are woefully understaffed. It is only because of their enthusiasm and commitment to providing the best service possible that I would rate the Irish maternity services as some of the best in the world (Health care worker/ professional)

The issue of staff shortages and its impacts on the quality of care are discussed further in relation to aspects of the services that are not working well.

b) Midwifery led care

Many respondents spoke favourably about midwifery care including midwifery led units, community midwives and home birth midwives. According to a number of respondents midwifery care is preferable as it is in their view more cost efficient and appropriate for women whose pregnancies would be classified as 'low risk'.

I think the midwife led care works well and should be the norm for most women in this country. Midwives are best placed to deliver cost efficient and safe care to women as they are the specialists in normal birth. I would like to see more midwife led units and services (Service user)

A large number of service user respondents had high praise for the Domino community midwife scheme in particular. This scheme is currently operating as part of the services from the Coombe, the National Maternity Hospital, Cork University Maternity Hospital, Rotunda, Wexford General and University Hospital Waterford. The Domino scheme facilitates access to antenatal and postnatal care by a team of midwives in their communities. These first time parents had a very positive experience of the Domino scheme:

My partner and I recently took part in the domino community midwife scheme. We found this absolutely brilliant. The level of care provided by the midwives was absolutely brilliant. This is a fantastic service. Even the aftercare provided by the midwives was invaluable to us as we were first time parents (Service user)

A positive account of the scheme was supplied by a number of respondents. Many of those who had direct experience of the Domino scheme highlighted the reduced antenatal appointment waiting times, the quality of antenatal classes and the follow-up support as the main advantages of this model of care. The early discharge scheme which allows women to leave the hospital soon after the delivery and the outreach clinics was also viewed positively.

These schemes allow women to be cared for in the community during their antenatal period, go home early after delivery and promote continuity in the postnatal period and overall satisfaction of women and these schemes have been shown to enhance national breastfeeding rates. This also frees up time and space in the hospital to allow women who do have risk factors in pregnancy to be cared for in an organised, swift and professional manner (Health care worker/ professional)

c) Home Birth Care

A substantial number of service user respondents had direct experience of home birth services as 11.5% indicated the home only option was used for their intrapartum care (see Table 9). At present, the National Maternity Hospital and University Hospital Waterford offer a home birth service. In addition the HSE facilitates a home birth service to eligible expectant mothers who choose to have a home birth under the care of a self-employed community midwife. Supports for home birth services are also available privately. The main advantages of a home birth highlighted by respondents were the individualised, non-medicalised approach to care during labour and the high quality antenatal and postnatal support provide by the home birth midwives.

The care provided by the homebirth midwives has been in my experience exceptionally good. Being heard, having the vagaries of your body respected, being attended in a non-medicalised situation by a woman entirely focused on you and your baby is beyond compare with the equivalent care in hospital (Service User)

For those, like myself, who have a normal pregnancy, and are lucky enough to be able to access a Community Midwife to avail of the homebirth service this service is incredibly good. The service in many ways is the polar opposite to what is normally received in the hospital setting in that one is given individual and specific care from a midwife(s) who have developed a relationship with you (both expectant mother & partner) (Service user)

d) Hospital Care/ Maternity Units

Although the majority of respondents advocated a midwifery led model, particularly for low risk normal pregnancies, others used the opportunity to highlight the role and importance of consultant led teams. Specifically, the quality of consultant led hospital care in the context of complex or high risk pregnancies.

Women with complex pregnancy are cared for very well e.g women with diabetes, cardiac disease etc. however, the percentage of women with a complex pregnancy is only 30-35% of the total number of pregnant women. These women receive consultant-led maternity services and are therefore cared for by the most appropriate lead professional (Organisation)

A small number of respondents highlighted the role of hospital staff in responding to an emergency during delivery.

The speed at which a team respond in an emergency is absolutely amazing. Without doubt my daughter is alive because of this (Service user)

Safety and the overall quality of public hospital care were highlighted by a number of respondents. Some suggested that The Irish Maternity Early Warning System (IMEWS) was working well and some respondents pointed to data which shows that Ireland has some of the lowest neonatal and maternal mortality rates in the world.⁷

The care I received in the hospital was excellent. I felt safe and supported by the nurses and midwives (Service user)

As 25% of respondents had received their care privately a number of these expressed their positive experience with private care. In particular, some highlighted the ability to select the consultant and have greater continuity of care as an advantage of the private model of care. However, this view was only put forward by a small number of respondents, as the majority of respondents had a preference for the choice of midwifery led care.

e) Antenatal and Postnatal care

Positive aspects of the antenatal care system were also highlighted by some respondents, namely that it was free and of good quality. In particular, a number of respondents highlighted the value and advantages of shared care between GPs and hospitals. Specifically for some respondents, this allowed services user to receive more personal care in a timely manner.

⁷ The exact definition of the rate (neonatal and maternal mortality) used by respondents is unknown.

I found that I could have the best of both worlds, the care of my GP and her team whom I have an existing relationship with, and the care of the staff in hospital. This made my antenatal care more personal (Service user)

Overall, few respondents stated positive aspects of postnatal care. However, for these particular service users the mental health support of the PHN was seen as an important strength of postnatal care.

The care to my home after release was excellent as I was alone the phn was clear that I could call for support and did ask plenty of questions re my mental health at that point. I breast fed and the clinic in [town] was very good at that point 2013. (Service user)

Public health nurse and GP was excellent with me before and after birth especially as I suffered PPD and anxiety (Service user)

f) Access, Cost and Choice

A number of respondents highlighted that the *Maternity and Infant Care Scheme*, which stipulates free care for women ordinarily resident, as a key asset of Irish maternity service. According to some respondents free access contributes to equitable service provision for all women.

The fact that maternity care is free in this country is something we can be proud of. (Service user)

We care for all pregnant women regardless of income race religion sexual orientation equally. (Health care worker/professional)

In addition, the access to maternity care across most geographical locations was also highlighted as advantageous.

The mother and infant scheme means that care is available free of charge to all women, and in general people can receive care in a geographically proximate location (Health care worker/professional)

While a lack of choice is highlighted as a key deficit of the current system (see analysis of question 17), a number of respondents stated that the move towards midwifery led care was working well.

The introduction of midwifery led care is a step in the right direction giving women more choice and allowing them to be involved in the planning of woman centred care and giving feedback to those delivering and planning each woman's individual care (Service user)

g) Specialised services

A small number of respondents reported they had experienced of loss. Although some respondents reported the care they received following their bereavement was high quality, this was not the majority experience.

We lost our baby at 38 weeks and the care we received was amazing from the [hospital] (Service user)

Other highlighted positive experiences of staff and care in neonatal care units. For this particular respondent the compassion shown by nurses and doctors when their son was ill was a positive aspect of their experience.

The neonatal unit, nurses and doctors we encountered during our sons stay at the [unit] were incredibly kind, compassionate and comforting at a deeply distressing time. They explained things clearly and took the time to support us and answer any and all questions that we had (Service user)

Some respondents highlighted positive experiences with a number of specific services including; diabetes services, and antenatal and postnatal physiotherapy. Others stated that the progress on supporting breastfeeding has been a positive development.

Breastfeeding rates have increased slowly in some areas of the country breastfeeding rates have exceeded annual national targets. Nine of the 19 maternity units have been designated as Baby Friendly Hospitals, meeting the Global Criteria of the BFHI. All maternity units are participating in the WHO/UNICEF Baby Friendly Hospital Initiative, with the remaining units working towards designation (Organisation)

However, from a service user perspective, breastfeeding support is viewed as key weakness of the current system. This is discussed further in the section on aspects of the services that are not working well.

h) Nothing

Some respondents could not outline any aspect of the current maternity service that they viewed as working well. Many of the issues raised by this respondent are expanded upon in the next section.

I thought about this, but really can't come up with anything. To me the system has it the wrong way round. Women's welfare and choices of care should be a top priority in maternity care, but really aren't from what I have seen (Service user)

Q. 17: In your view, what is not working well and how can it be improved?

In total, 1324 responses were received on question 17 resulting in approximately 90,000 words of text. The themes arising from the analysis of this text were as follow:

- Poor breastfeeding support.
- Limited care options and a lack of choice.
- Medicalised model of childbirth for low risk women.
- Overcrowding and a lack of resources and staff.
- Women not seen as partners in their care.
- Poor staff communication.
- Antenatal clinic waiting times.
- Poor quality antenatal and postnatal care.
- Limited mental health supports.
- Unsatisfactory care following a loss or bereavement.
- No continuity of care.
- Access and inequality.
- Lack of transparency and accountability.

a) Breastfeeding support

The main theme to arise from the analysis of respondents views on what is not working well was the lack of breastfeeding support in the hospital, community and home setting. In particular, the lack of support on postnatal wards following delivery was highlighted as a key deficit of the current maternity service by a large number of respondents. The main issues identified by respondents were staff shortages on postnatal wards, little or no access to lactation consultants, a perceived pressure to use formula and a lack of breastfeeding advice/information from hospital staff. For some respondents there was a striking contrast between the emphasis on breastfeeding during antenatal care and the lack of support during the postnatal period. The emotional impact of not reaching personal breastfeeding aspirations was outlined by this respondent:

I stayed only one night in [hospital] and I was very encouraged to breast feed but I was given little to no support with this in the wards. When I did ask for support the nurses were very short in their time and manner as again they were so under

resources. This contributed to my child's blood sugar levels dropping at home and a he may have had to be readmitted luckily he did not need to be.After attending all my ante natal classes in [hospital] and being told that breast is best I was then experiencing a lot of maternal guilt and conflict about not breastfeeding. If this government is promoting breast as best they need to support this message with real resources (Service user)

Many respondents suggested that in order to increase breastfeeding rates more staff training, greater numbers of lactation consultants and measures to address staff shortages are required. The culture of infant formula 'top ups' on postnatal wards was a key issue identified by respondents. A number of respondents used the term 'bullying' in regard to the promotion of formula by HCP. Many suggested that infant formula should not be available for free and some specifically mentioned the implementation of the *WHO Code of Marketing of Breastmilk Substitutes*.

Although lip-service is paid to breast-feeding, actual support in hospitals and from public health nurses is woefully inadequate - there needs to be true commitment to change, training and resourcing. It would help if formula was not handed out like smarties for free in all the wards (Service user)

Diagnosis of tongue/ lip tie was another issue raised by respondents in regard to breastfeeding. For a number of service user respondents there was a delay in the diagnosis which impacted negatively on their success with breastfeeding. This particular respondent highlighted that in their experience they had to access this service privately.

As it happened the baby was tongue tied and that was the reason it wasn't working for us. I just felt that while the antenatal care was excellent and I had such a good experience with the labour and delivery, the aftercare really lacked in comparison. There needs to be more lactation specialists on hand and they need to have the time to spend with you and get to the root of the problem. Also, there needs to be an option to have tongue tie releases performed in the maternity hospital. I had it done privately, but it is my understanding that even had it been diagnosed in the hospital I would have been referred elsewhere for the procedure (Service user)

Some recommended that mandatory tongue/lip tie assessment be carried out in hospital following delivery and before discharge. The procedure to address this issue should be carried out once the diagnosis is made according to a number of respondents.

In conjunction with a lack of breastfeeding support in the hospital setting, many respondents stated that postnatal breastfeeding support in the community is also poor. Inadequate provision of community breastfeeding nurses, limited engagement with PHN and poor GP support were identified as the main areas for improvement in regard to community based breastfeeding support.

Post care in community was poor, no community breast feeding nurses. On milestone appointments no knowledge in relation to managing allergies in infants. Eg allergy to milk or intolerance to milk. Both my children had admissions to hospital for blue baby and anaphylaxis no follow up in the community no support (Service user)

A number of respondents suggested that postnatal community and home based midwifery services were successful in increasing breastfeeding rates and accordingly access to this type of care should be expanded.

Inconsistent and poor quality information in relation to breastfeeding by HCPs was another aspect of Irish maternity services that was viewed unfavourably.

Breastfeeding support has always been poor in my opinion. Have come across so many staff with outdated information and the main reason I have successfully breastfed 3 children is because of a very pro breastfeeding family and circle of friends. Might not have been the case if I was solely depending on maternity breastfeeding services (Service user)

Consistent staff training was highlighted as a way to address this issue. In addition a number of respondents advocated the full implementation of the Baby Friendly Hospital Initiative and the HSE Breastfeeding Action Plan.

Lactation advice is often very poor and is sometimes offered by hcps who are not up to date in this area. All professionals who work with breastfeeding mothers and/or their babies need mandatory, regular updates on lactation management. This could be similar to the NRP or stable programme. (Healthcare professional/worker-Lactation Consultant)

Can be improved through multidisciplinary approaches by developing breastfeeding support structures investing in training and skills development for staff and auditing practices to ensure that policies are being implemented (Organisation)

Despite an overwhelming focus on the lack of breastfeeding support by those who responded to the consultation, a small number of services users (n=4) suggested that too much pressure is placed on women to breastfeed in hospitals and information on bottle or combination feeding should be provided in conjunction with breastfeeding support.

The pressure on women to breast feed. No information is provided about bottle or combination feeding (Service user)

I had to beg for a bottle to feed my baby. I was told they are not allowed to give them out. So I was supposed to leave the baby hungry?? in the end I had to go to the nurses station to get a bottle as she told me she'd bring it back but never did (Service user)

b) Lack of choice and access to midwifery/ home birth services

The lack of choice in maternity services was a key theme identified in the analysis of question 17. The need to provide a range of alternative care options to consultant led care was proposed by service users, health care professionals and organisational respondents. Further investment and support for midwifery led care and the expansion of schemes such as Domino, Early Transfer Scheme and hospital based water births was suggested. The view that the number of options available to women is often dependent on their location was common.

Lack of choice for women in Ireland, predominant model is obstetric led care. Need to invest in resources so the midwife as the lead professional can be promoted and implemented. Different levels of service available depending on location eg domino scheme, water births. midwife led services etc. All women should have an equal opportunity to choose the type of service they wish (Organisation)

The lack of services for women around maternity care. The fact that there is so little choice - it's a bit like a lottery. Birth options are often dependent on where you are living (Service user)

As already outlined a number of respondents proposed that midwifery led care is the most appropriate setting for 'low risk' pregnancies. The model of midwifery led maternity services in the UK and Northern Ireland was highlighted as an exemplar in this regard.

We need to move from an obstetric-dominated, risk-focused service, to one which focuses on normality, provides meaningful and realistic choice, and empowers and supports women. In NI the maternity strategy has done exactly that, and they are moving towards a service where midwives are the first point of contact, where low risk women may never see an obstetrician, where home birth, Domino and midwife-led units are becoming the norm for healthy women (Service user)

There was a strong emphasis placed on expanding and developing home birth services in Ireland. The view that the home birth option should be a part of the overall maternity services package in Ireland was advocated by a number of respondents. Furthermore, respondents proposed that the perception among HCP (in particular consultants and GPs) and the public that home birth is unsafe needs to be changed.

Homebirth is not seen as a viable option for giving birth by most women, even though they are healthy and are experiencing a normal, healthy pregnancy. Homebirth is still viewed as an 'alternative' way of giving birth and this is a shame. There needs to be more community midwives, support for these midwives and education amongst the general public about the safety of giving birth at home for those experiencing a healthy pregnancy (Service user)

In regard to home birth services, one organisation suggested that improved clinical governance for self-employed community midwives and better integration between home and hospital services would be welcomed.

A number of respondents also suggested that the establishment of independent birth centres would facilitate greater choice for women.

Difficulties associated with receiving information on the care options available (particularly home births) and local services were raised by a number of respondents. GPs were identified by some service users as being uninformed on the options in terms of maternity services.

Women do not know that they have a choice with their maternity care. Doctors do not even know what birth services and options are available to women in their local area (Service user)

Many recommended that a centralised information service on maternity care options be established. The most commonly cited format for this information was online.

c) Medicalised Model and the Role of Interventions

A large number of respondents raised concerns about the number of interventions (including reference to medical and surgical interventions) women receive during the intrapartum period. Specifically, respondents pointed to the high rate of caesarean section, use of forceps/vacuum and induction. Many recommended that maternity services move away from the active management of labour to an approach that focuses on a natural birthing process.⁸ The provision of water births, active labour (i.e. space to move around during labour), and upright birthing positions was recommended by some respondents.

The hospital based, medically led system that is the norm across Irish maternity units is deeply flawed. Statistics for medical intervention in birth reveal a widespread pattern of over medicalisation, resulting in a unacceptably high rate of induction that can be traced directly back to hospital policies regarding actively managed births, which themselves are driven by overcrowding, bed management and an outmoded and unsafe approach to maternity care – and not by woman and baby centred expertise in providing care for normal births (Service user)

The issue of informed consent was raised with reference to interventions. Many respondents felt that women were disempowered during labour and delivery and were not given the opportunity to make informed decisions regarding their care. In addition, service users'

⁸ The Active Management of Labour is a term used to describe the approach to the prevention of a prolonged labour (defined as 12 hours or more).

experience of maternity services left them feeling that they were not listened to and that their desired care plans were not adhered to. The need to facilitate informed consent in relation to interventions was advocated by many respondents.

Hospital policy with regards to intervention really needs to be examined. In my case I strongly believe that intervention actually put both my baby and I at increased risk, I think the practice of induction 10 days post dates is too soon and not backed up with sufficient evidence. I was on my way to a failed induction and C section but thankfully I progressed....Maternal choice is given very little weight and I would argue that a lot of consent to procedures is implied and not true informed consent (Service user)

However, some respondents voiced the opinion that interventions are required in some cases and a focus by hospitals on reducing C-section rates could compromise safety.

Information regarding c sections, and subsequent births. The unmedicated vaginal birth is heralded as the holy grail, however in many instances this cannot happen for many mothers(including myself). Emergency c sections are not called soon enough and mother's undergo horrific trauma as a result. They are wrecked after attempting a labour that would never progress making caring for a newborn afterwards difficult. Maternity services should concentrate on that instead of making sure Ireland's c section stats are low (Service user)

A number of services users highlighted that in their experience it was difficult to access pain relief during and after the delivery.

d) Overcrowding, Resources and Staffing

Hospital overcrowding, in particular on the postnatal ward, emerged as a key theme in regard to aspects of the current service that are not working well. In particular, inadequate numbers of facilities such as toilets and showers and the lack of privacy on hospital wards were viewed by many as unsatisfactory. The quality of food and some hospital rules which limited access to food after 5pm were also viewed negatively. These concerns were usually raised with reference to the nutrition requirements for breastfeeding women.

I spent the early part of my labour in a large ward with 11 approx other women also labouring. It made me feel like I wasn't much better than an animal that was just being waited on to give birth next (Service user)

The hospital was not fit for purpose. overcrowded. dirty. rude and unprofessional catering and domestic staff. poor diet provided and no suitable common areas in hospital for the long stay patients. psychological care was not a priority and 6 bedded dorms are not suitable for long stays either or postnatally with 6 women and 6 babies per room . showering / toileting facilities were absolutely dire 3 toilets for 30 ladies on an antenatal ward. The wards are noisy and chaotic and not conducive to enable

nurses provide holistic care. no privacy for patients to speak with visitors their partner or have a private review by their doctor (Service user)

The issue of staff shortage and overworked HCPs was identified as a key deficit of current services. According to a number of respondents (both HCPs and service users) understaffing and excessive workload may compromise care and safety issues.

under staffed, not enough midwives to adequately cover the birth rate. more need to be employed before a serious accident or a preventable loss occurs (Service user)

Care for women and babies is been compromised due to the serious lack of staff. Midwives don't have enough time with women to truly provide best care. Stressed midwives = taking short cuts "to get the work load done", women should not be subjected to this. It is and unsafe environment (Health care professional/ worker)

In addition, the limited scope for continued professional development was a concern for some respondents. This HCP suggested that within the current system there is very little incentive to receive more training or education.

we are under massive stress as frontline staff work cultural norms which were completely unacceptable years ago are now becoming the norm 6-8 babies minded by 1 nurse. standards are slipping completely !! stress levels are unbelievably high people are at breaking point. the wait list for reduced hours is 8 years !!!! There is no motivation to better yourself-5 study days for a masters course (8-4 x3 days) (Healthcare professional/ worker).

Overall, there was a strong emphasis placed on the need to increase the number of qualified frontline staff in Irish maternity services. This organisation pointed to the requirements for a standardised staffing model, in particular in relation to the consultant numbers.

Consultant, midwifery and nursing recruitment and retention issues need to be urgently addressed and a national/standardised staffing model agreed. Consultants numbers should be based on the RCPI Institute of Obstetricians and Gynaecologists (IOG) Review of Workforce Planning document (2014) (Organisation)

e) Women-centred care

In conjunction with the issue of informed decision making outlined above, many respondents expressed the view that women are not listened to within the current maternity services. For a large number of respondents the need to place women and their wishes at the centre of their care was considered paramount. This quote is illustrative of the experience a number of service user respondents.

I didn't have a say in how I wished my birth would go, I felt like I was a number and didn't matter..... I felt the consultants team members were dismissive of my feelings regarding their choices for me and felt like I was a puppet with no voice going through a first pregnancy is scary enough without being made feel like I had no control or say with anything that was to be done to my body. Communication needs to be improved greatly, a woman should be made feel part of the process not just an instrument in it! (Service user)

A number of respondents also stated that in their experience they were not afforded dignity and respect during their maternity care.

There is so little respect shown to women in Ireland during the process of birth which should be a happy occasion. You're just treated like a slab of meat in a hospital (Service user)

It was recommended that greater recognition of women's voices and a holistic focus on their needs is required across all aspects of the service, but in particular during intrapartum care.

f) Staff communication and interpersonal skills

While many respondents praised the work of frontline staff and the quality of care they received, others had negative experiences in regard to their interactions with staff. Poor interpersonal skills of staff in hospitals were raised by a number of respondents.

Hospital staff are ignorant, abusive, condescending, they are answerable to nobody and have a lack of regard for those they "care" for I lodged numerous complaints about upward of 10 people that I came across. Some of these people should not be allowed to work in a "care" setting or with people at all, they got away with a slap on the wrist if that (Service user)

Poor communication by HCP and inconsistency in the information received from them were also highlighted as key issues in relation to staff skills. In addition, poor communication between staff and an absence of multidisciplinary teamwork were also viewed as a key weakness within the current system. In particular, communication between consultants and other members of staff could be improved according to a number of respondents.

I was not given adequate information about my situation. The communication between junior doctors and consultants led to a lot of misinformation being passed on to me. This led to an enormous amount of stress (Service user).

g) Antenatal clinic waiting times and access to scans

A significant number of respondents were critical of the appointment system and waiting times in antenatal clinics. Within the present system, a number of women are given the same

appointment time which leads to waiting times of up to three or four hours. Respondents used terms like ‘conveyor belt’ and ‘cattle mart’ when describing their antenatal clinics. Reform of the current appointment system (i.e. each women receives a specific time slot) was advocated by a large number of respondents. The movement towards community midwifery led care, outreach clinics and shared care were also suggested as a solution to overcrowded antenatal clinics.

They system is very much like a conveyor belt and not a very efficient one at that. For example as a public patient there were frequently three hour waits to be seen at the ante-natal clinic. To me that is unacceptable and there must be a more efficient way to run an ante-natal clinic. There was never any apology for this wait - it is just a given that this is the way the system is (Service user).

In addition to long waiting times, there was a strong emphasis placed on the limited time allocated for one to one engagement with consultants during the antenatal appointments. The lack of continuity of care raised by this particular respondent is discussed further below.

All women should be offered a first scan by the public service in a timely manner. Patients attending antenatal clinics complain that they do not feel they have enough time during the consultation to raise their concerns and ask questions, they often do not know the name of the doctor or nurse they were seen by, they are seen by a different person each time, and there is lack of continuity of care (Organisation)

A number of respondents suggested that there should be more scans available and that they should be made available earlier.

I find the care very poor in the first 4 months of the pregnancy. It would be extremely important to do early scan to screen the right position of the embryo or diagnose miscarries. In general I think it would be more scan needed during the pregnancy. I think women have the right to know if they face with any likely disability of the child as early as it is possible (Service user)

The inconsistency in the provision of an anomaly scan across hospitals was also highlighted as a key issue. This organisation called for a standardised approach to screening for foetal abnormalities.

Services for detection of genetic foetal anomalies are not provided in the country. Amniocentesis and CVS samples are sent to UK for analysis. Modern methods of non-invasive detection of cell free foetal DNA are not available here. A standardised approach to ordering and interpreting specialist investigations is required (Organisation)

h) Quality of antenatal care and advice

While a number of respondents praised the quality of antenatal classes/care, some suggested that much more could be done to provide information on the benefits of a healthy lifestyle (diet and physical activity) during pregnancy, better and more consistent information on breastfeeding, and more information on care choices in the community. Overall, the provision of shared care between hospital and GPs was rated favourably, but a number of respondents suggested that GPs could be better informed on maternity services and in providing antenatal advice.

i) Accessibility and quality of postnatal care

As already outlined in regard to breastfeeding and hospital overcrowding, care on postnatal wards was seen as a key deficit of the current services. As well as breastfeeding support, many service users suggested that hospitals should provide better and more accessible care for women's physical needs following the birth of their child.

Once baby is born, the after care is terrible. It takes at least a year for women to heal after giving birth. During this time services and support in the maternity hospital should be made available (Service user)

In this regard a number of respondents suggested that access to physiotherapy should be facilitated in the future.

I found afterwards not great I needed physio & it took a long time for me to get an appointment I found this very stressful & upsetting (Service user)

Lack of support in the community and limited access to the PHN service is another deficit in postnatal care identified by the respondents. Some called for the reintroduction of the policy requiring all PHNs to be trained midwives, while others called for more training to be provided. Many suggested that the frequency of PHN visits be increased. Others suggested that GPs play a greater role in community postnatal services.

Postpartum care for the mother is very poor, particularly in relation to GPs. If you are regarded as being complication free, you are pretty much left to your own devices. I think women are less likely to complain at this stage, unless they are experiencing something really horrendous, as their focus is entirely on the baby. GPs need to assess postpartum women much more thoroughly at their 6 week PP check up. Breast feeding is another area that needs to be urgently addressed as part of the National Maternity Strategy (Service user)

The expansion of midwifery led services was viewed as a means by which postnatal care could be improved.

j) Mental Health Supports

According to a number of respondents poor maternal mental health supports during the postnatal period were lacking in current services. In particular, the lack of postnatal care following a traumatic birth was highlighted by a number of respondents.

The complete lack of follow up after a traumatic birth. I was released from hospital after emergency section under GA & offered no follow up to discuss what had happened or check my physical/mental well being. As a result I spent many months with Post Traumatic Stress (Service user)

Greater access to mental health professionals throughout the pregnancy and postnatal period was recommended by some respondents. Recognition of the emotional needs of women by HCP was also emphasised as important;

Disregard for the absolute terror and fear experienced by first time mothers in labour. Many pregnant women feel very vulnerable and petrified, and there is a need for a specific care professional, possibly counsellor, take sole responsibility for giving emotional support before, during and after the birth. Right of expectant women to refuse internal exams and that right to be respected and no guilt trips to be given to woman. That aspect is shockingly absent.. Traumatic experiences often result in postnatal depression (Service user)

It was recommended by a number of organisations that maternal mental health is fully integrated into maternity care and a consultant perinatal mental health psychiatrist is linked to every maternity unit in Ireland. Reference to better adherence to the NICE guidelines on antenatal and postnatal mental health care services was also made.

k) Poor Quality Loss/ Bereavement Services

The main criticism of bereavement services according to those that responded to question 17 was the lack of dedicated hospital space with adequate privacy for those who have experienced a loss. The need for privacy and separate facilities was also advocated for those who receive a diagnosis of a fatal foetal abnormality.

Facilities. I attended [hospital] and was an inpatient prior to the loss of my son at 33wks. No private room was available prior to the loss and the room used post loss is wholly inadequate positioned beside the pre delivery ward with no privacy and very noisy. No funding is available to provide counselling to those who suffer stillbirth (Service user)

The need for counselling and other follow up supports for those who experienced a loss was outlined by some respondents. In particular, this respondent outlined the need for specifically trained hospital bereavement staff.

More information to bereavement therapists would have been very beneficial. A member of staff dedicated specifically to babies who were dying or going to be living very challenging lives (Service user)

The need for staff training in regard to dealing with a loss also came up in reference to poor staff interpersonal skills. A perceived lack of compassion and empathy by staff was identified as a failing for those who had experienced a loss.

Management of Parents receiving news of loss of Baby is completely unacceptable (Healthcare professional)

One organisation recommended that the forthcoming HSE bereavement standards be implemented and a national model of neonatal and perinatal palliative care developed.

1) Inconsistency and no continuity of care

The need for continuity of care between different settings and between HCPs was a key theme to emerge from the analysis of question 17. For many service user respondents, at each hospital visit they dealt with different doctors, consultants and/or midwives. This sometimes led to miscommunications and poor continuity of care.

Assigning 2/3 consultants to a group of expectant mothers in public system. I saw over a 10 during pregnancy and after...had complications. Was in and out of hospital for 2/3 weeks. had to explain to each new doctor what had happened...at times wires were crossed. This could have been prevented if I spoke to the same 2/3 consultants. There were serious mistakes made with medicine dosage that could have had very damaging effects (Service user)

Many expressed the view that continuity of care ensures a more personal and individualised care experience. A number of respondents suggested women should be assigned a midwife and/or consultant in order to build up a relationship with their healthcare provider.

There is no continuity in so far as you do not see the same mid wife or doctor each visit. A better system whereby mid wives and or doctors are assigned a particular group of women to care for during their pregnancy would be of benefit as it allows the opportunity to build up a relationship with that professional (Service user).

Sharing data between hospitals, in particular for women using a different hospital for their second or subsequent birth, was also seen as an aspect that could be addressed to ensure

continuity. The movement away for paper based records to electronic versions was also advocated.

For those that had experienced a home birth, continuity of care was viewed as a key advantage.

I was lucky to have a home birth and to have the same midwife. I feel continuity of carer is key to making a difference and more community and home based care options for low risk women (Service user)

Inconsistency in the quality and provision of care across hospitals was another theme identified in question 17. Differences in hospital policies on calculation of due dates and induction policy were highlighted by a significant number of respondents. The need for standardised evidence based guidelines across all hospitals was advocated by many.

Non evidence based care women are routine subjected to because the hospitals have failed to roll the guidelines. Hospitals have different policies on for example due dates (Service user).

Limited implementation of evidence based practice in current Irish maternity services emerged throughout the analysis. The need to implement the NICE and WHO recommendations on maternity care was raised by a large number of respondents.

Speaking as a consultant surgeon and a woman who gave birth this year, I was absolutely dismayed by the attitude adopted towards evidence-based practice. NICE & WHO & HSE recommendations on management issues such as episiotomy vs natural tear, upright position in second stage of labour, neonatal blood glucose testing, and many other aspects, are not followed in favour of antiquated hospital policies (Service user)

In addition, many respondents stated that the same standard of care should apply to all hospitals and should not differ based on geographical location or size of maternity unit. Differences in safety records between hospitals were raised by a number of respondents.

The highest standards of care should apply in every maternity ward in the country however that does not seem to be the case in some regional hospitals which must be very distressing for the mothers who have no choice but to use those hospitals when giving birth. There needs to be transparency, more visible accountability and a willingness to change from within the system when things go wrong (Service user).

What is not working well is that there is not a minimum standard of consistent maternity care countrywide . Women and partners should not have to worry that the healthcare they may receive in a maternity service could be substandard and lead to a life threatening situation for both mother and/ or baby. It comes down to education, training and accountability (Service user)

m) Access and Inequality

The issue of geographical inequality was also mentioned in regard to access to maternity services, whereby those in Dublin had access to a wider variety of services.

It's disheartening to see that the range of ante and postnatal care and birthing options that are available in major urban areas (aka Dublin) are not available in smaller hospital catchment areas. As someone who lives rurally I would love to be able to avail of home based antenatal and post natal care. Unfortunately I'm ineligible for home birthing due to a number of factors (Service user)

Inequalities in the provision of care between public and private patients were also highlighted. A number of respondents suggested that private beds should not be made available in public hospitals. This respondent who had accessed care privately stated that the standard of care should be the same regardless of your ability to pay for private care.

The support during the pregnancy I felt was poor. I was totally reliant on my consultant who I had engaged privately. This should not be necessary, you should be able to get the same level of regardless of whether you are a public or private patient (Service user).

A number of organisational respondents also suggested that services should be better prepared to address the needs of socially excluded or potentially vulnerable women such as those from disadvantaged backgrounds, women with hearing difficulties, members of the Travelling community and/or ethnicity minority background.

n) Transparency and Audit

Greater transparency and structured audits in regard to safety/ quality and clear reporting mechanisms are needed according to a number of respondents. Hospital data on outcomes and clear structures on accountability were identified as a priority.

We fail to collect robust data on outcomes, fail to detect patterns, fail to learn from serious incidents, fail to disclose. We need a structure with explicit lines of who holds responsibility and accountability. We can no longer blame an inanimate 'system' (Service user)

Robust mechanisms are needed to adequately investigate and respond to quality issues, including appropriate resource allocation, workforce planning and training (Organisation).

A number of service users also sought a clear complaints/ grievance procedure in all hospitals.

o) Other

A number of issues emerged from the analysis of question 17 that fell into the ‘other’ category as they were not mentioned frequently enough to constitute a theme in their own right.

A number of respondents made direct reference to the constitutional ban on abortion (8th amendment) and how this may compromise women’s safety and autonomy. It was also highlighted in reference to parents who have received a diagnosis of a fatal foetal abnormality.

Some respondents had a negative experience of services when their newborn was diagnosed with special needs. In these cases, the diagnosis was not communicated in a sensitive, supported or timely manner.

Respondents who had gestational diabetes stated that the care received in outpatient clinics was poor. Long waiting times and poor quality or inconsistent information were the key issues identified.

The need to highlight the benefits of a healthy weight for conception and pregnancy was also raised.

In terms of facilities, a number of organisations highlighted that maternity hospitals need to be co-located with adult hospitals.

Some respondents suggested that greater measures to facilitate the involvement of partners in maternity services are required. In particular, a review of visiting times is needed according to some respondents. Others suggested that paid paternity leave needs to be introduced. Others called for a more family friendly service, which incorporates the needs of other family members.

In addition, two organisations suggested that there is a need for greater awareness surrounding alcohol consumption and pregnancy. In particular, awareness programmes for Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder. Recommendations for more awareness of the harms of smoking during preconception and antenatal care were also made.

Finally, some respondents pointed to the need to make specific services such as speech and language therapy, homeopathy, birth doulas and services for vulnerable or socially excluded women more widely available. The role of pharmacists in providing antenatal/ postnatal advice in the community was also highlighted.

3.4: Suggestions for Improvement to Maternity Services

In this section respondents were asked to list their top three priorities for each stage of care in ten words or less. The responses to questions 18 to 23 were coded into categories based on similarities in the answers received. For spacing and efficiency purposes, only first preference priorities are listed. Similar responses were found for second and third priorities.

Q. 18 - 23: Please list your suggestions for improvement, in order of priority for the following stages of care.

- 18) Advice and care on getting pregnant (up to 3 months before conception)
- 19) Care during pregnancy (antenatal care)
- 20) Care during labour (intrapartum care)
- 21) Care for mothers following baby’s birth (up to 6 weeks after birth)
- 22) Care for babies following birth (up to six weeks after birth)
- 23) Care for those who have experienced a loss

3.4.1: Priorities for Advice and Care on Getting Pregnant

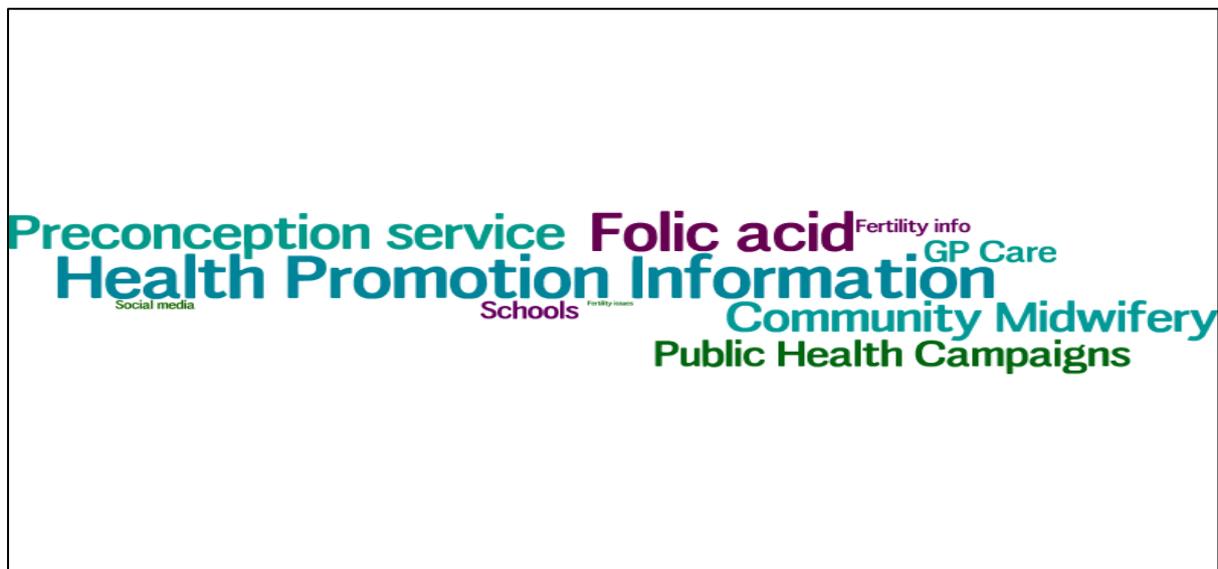


Table 9 displays a detailed breakdown of respondents’ priorities for the improvement of preconception care (generally defined as three months before conception). Overall, there was limited engagement with this question as only 55% of valid respondents provided an answer.

The most frequently cited response (17%, n=126) was that information on the benefits of maintaining a healthy lifestyle be made more widely available. This included information on the benefits of a healthy diet, reducing alcohol consumption, smoking cessation and increasing physical activity for conception and a healthy pregnancy. Other respondents (7.2%, n=52) suggested a more general public awareness campaign on healthy living, while 5.7% (n=42) advocated raising awareness on these issues in schools (in particular among girls). In addition, 11.8% (n=87) viewed increasing folic acid awareness as a key priority. There were also a number of respondents who suggested that specific information on increasing fertility (3.9%, n=29) and on pregnancy issues for women with pre-existing medical conditions (3.1%, n=23) should be prioritised. Several respondents proposed that services for people experiencing fertility issues should be prioritised (3.5%, n=26). A number of respondents advocated that information would be provided in an online/social media format (3.8%, n=27), while others suggested printed material would be preferable (2.2%, n=16).

A smaller number of respondents (9.6%, n=69) specified the need for specific preconception services or highlighted that at present there is very little preconception care and advice available in Ireland. A number of respondents suggested that such services should be midwifery led and provided in the community (8.4%, n=61). While others stated (5.7%, n=42) that a GP led preconception service would be preferable, a further 10 respondents stating that shared care would be optimal during this stage of care (i.e. GP and hospitals). In total, 25 respondents suggested that more information on the type of care available (community, hospital & home etc.) could be made more available during the preconception stage. Other priorities raised by respondents included information on mental wellbeing during and after pregnancy, information on vitamins and supplements, access to complementary services (e.g yoga, homeopathy), age related information, breastfeeding information, the development of national guidelines, and that staff received more training on preconception health.

Table 9: *Suggestions for Improvement of Preconception care*

	Frequency	%
General information on a healthy lifestyle	150	20.3
Folic acid awareness	87	11.8
Specific preconception service/ programmes	69	9.4
Midwifery/ community services	61	8.4
Raising awareness/ public health campaigns	52	7.2
GP based preconception service or combined care	52	7.2
Awareness campaigns in schools	42	5.7
Information and education on increasing fertility	29	3.9
Information available online and through social media	27	3.8
Help with fertility issues	26	3.5
Information on care available/choices and local services	25	3.4
Information for women with pre-existing medical conditions	23	3.1
Mental wellbeing	16	2.2
Printed information (leaflets, poster etc.) or multiple formats	16	2.2
Other	60	8
Total	735	100

3.4.2: Priorities for Care during Pregnancy



Table 10 presents a detailed overview of respondents' top priorities for improvement antenatal services. Many respondents suggested that a community based model of antenatal care provided by midwives and GPs be prioritised (24.7%, n=274). The next most commonly cited priority (11.6%, n=129) was to reduce the outpatient waiting times at hospital antenatal clinics. Others also would like to see earlier scans and that scans occur more frequently during pregnancy, including consistency across hospitals in the provision of an anomaly scan (9.3%, n=103). This category also includes those who suggested that information on how to monitor the movements of the baby during pregnancy be more widely available.

Over 11% (n=124) would like further information on maintaining a healthy lifestyle during pregnancy (including those with pre-existing conditions such as diabetes), while 6.8% (n=75) would like more information on care options/pathways. Just over 5% emphasised prioritising breastfeeding advice during the antenatal period. Continuity and consistency refers to respondents view that antenatal care should be provided by the same HCP and that there is consistency in the care and information provided. Just over 4% (n=48) advocated that respect for women and their care plans should be the main priority during antenatal care.

A number of respondents suggested that the quality of antenatal classes as well as their availability could be improved. Some respondents specified that mental health and wellbeing and greater emphasis on labour preparation should be prioritised. Others suggested that antenatal care could be initiated earlier in the pregnancy (1.9%, n=21). A smaller number of

respondents pointed to addressing staff shortages, as well as staff training and interpersonal skills as a key priority within antenatal services. ‘Other’ in this instance refers to partner involvement/ support, access to physiotherapy services, access to complementary services, and providing information on caring for a newborn.

Table 10: Priorities for Improvement of Care during Pregnancy

	Frequency	%
Midwifery/ GP community antenatal care including Domino	274	24.7
Reduce waiting times in antenatal clinics	129	11.6
Information/ support on a healthy lifestyle	124	11.2
Scans/ screening/ monitoring	103	9.3
Continuity & consistency	79	7.1
Information on care options	75	6.8
Breastfeeding information	57	5.1
Respect and adherence to care plans	48	4.3
Availability and quality of antenatal class	39	3.5
Labour preparation	36	3.2
Mental wellbeing	33	3.0
More staff/ resources	24	2.2
Earlier initial care/assessment	21	1.9
Staff communication/ interpersonal skills/ training	30	2.7
Other	38	3.4
Total	1110	100

3.4.3: Priorities for Care during Labour

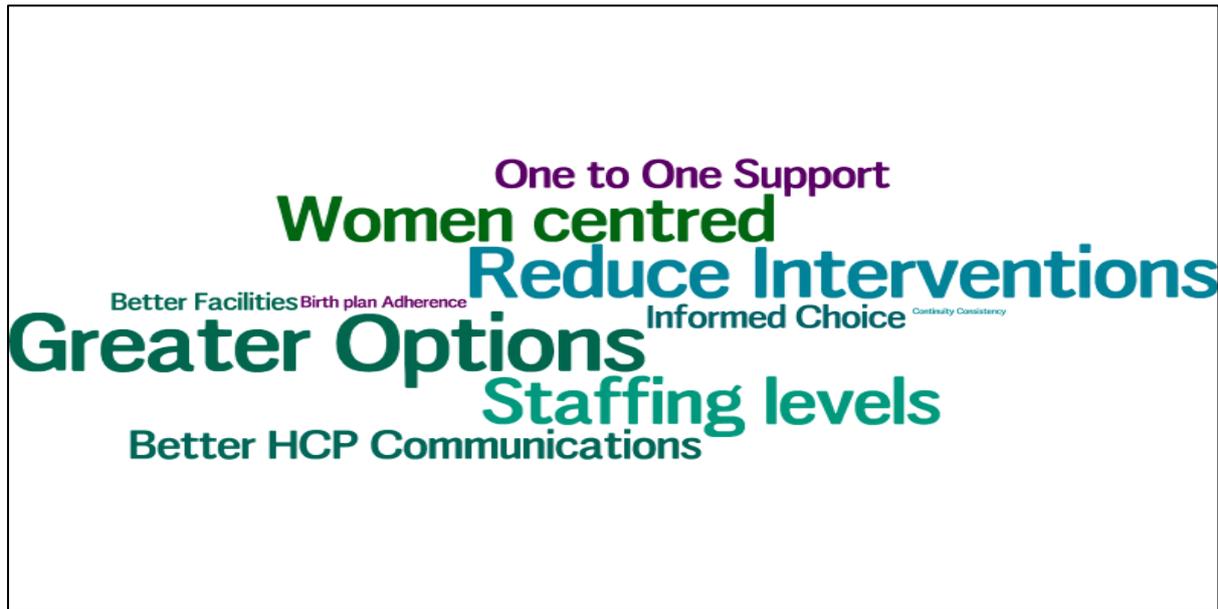


Table 11 shows that according to many respondents the availability of more care options (12.7%, n=168) and a reduction in interventions (10.3%, n=134) should be prioritised for intrapartum care. The need to address staffing levels was also advocated by a number of respondents (9%, n=120).

Better communication by healthcare professionals was also raised by a number of respondents (4.7%, n=67). This includes communication between the HCP and the service user, as well as communication between HCPs (i.e. between doctors/ consultants and nurses/ midwives). In particular, the need to improve multidisciplinary care was highlighted. A number of respondents would like to see more one to one care during the intrapartum stage of care (4.7%, n=62).

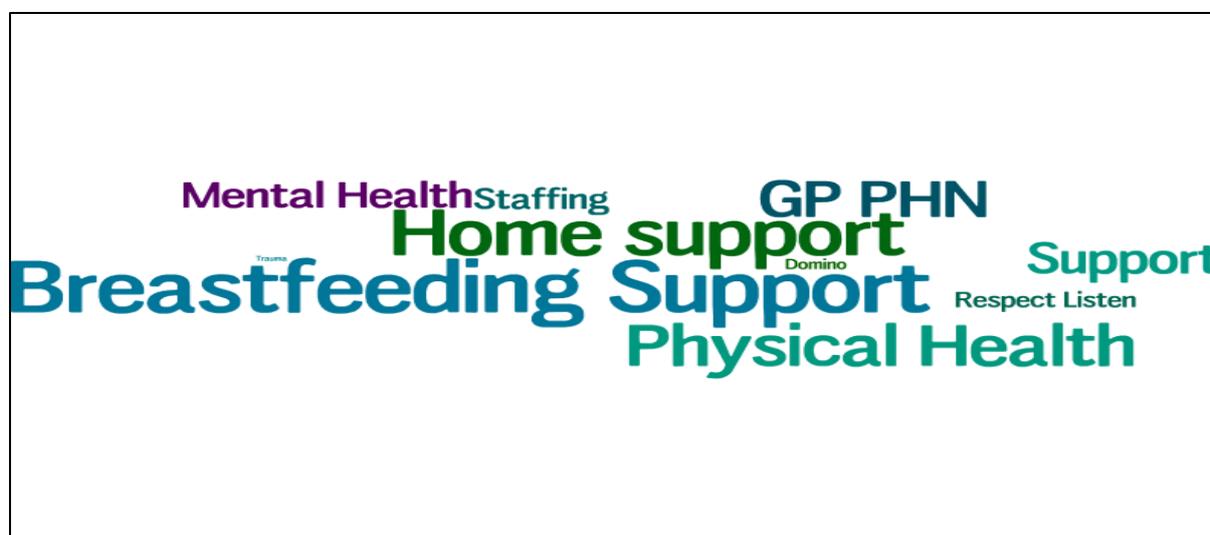
The issue of respect and listening to views, wishes and needs of women was the top priority for 7.8% (n=104) of respondents. Informed choice and decision making in regard to medical interventions and care plans (3.8%, n=50) and adherence to birth/care plans (3.1%, n=41) was also raised by a number of respondents. Others highlighted continuity of care (3%, n=40) and evidence based practice (2.2%, n=29) as their top priority for intrapartum care.

Staff training, privacy during and after labour, better facilities in hospitals, partner involvement, access to pain relief, mental wellbeing support, and access to complementary services were also highlighted as key priorities during intrapartum care for some respondents.

Table 11: Priorities for Improvement of Care during Labour

	Frequency	%
Greater options/ choice	168	12.7
Reduce the number of medical interventions	134	10.3
Adequate staffing levels	120	9.0
Respect and listen/ women-centred care	104	7.8
Better communication by HCP	67	4.7
One to one support	62	4.7
Informed choice/ decision making	50	3.8
Better facilities	45	3.4
Adherence to birth plan/ preferences	41	3.1
Continuity and consistency	40	3.0
Evidence based care	29	2.2
Staff training	28	2.1
Privacy	18	1.4
Partner involvement	18	1.4
Access to pain relief	14	1.1
Mental wellbeing	14	1.1
Other	11	0.8
Total	1006	100

3.4.4: Priorities for Care following the Baby's Birth (Mother)



The questions on postnatal care were split between priorities for mother and child. Table 12 shows that the top priority for postnatal care for mothers is breastfeeding support (34.6%, n=383). This includes support in the postnatal ward, support in the community, specialised support (i.e. more lactation consultants) and staff training on breastfeeding.

A number of respondents would like home based postnatal care to be prioritised (10.7%, n=119). Whereas, others had a community based model as their top priority, via GPs and/or PHNs (7.1%, n=79) or community midwives (7.1%, n=79). A smaller number specifically mentioned the need to expand the Early Transfer Scheme or the Domino scheme in regard to postnatal care (2.4%, n=27). The need to prioritise adequate staffing during the postnatal period was suggested by 48 respondents. Almost 10% suggested that mothers' physical care needs should be a key aspect of postnatal care, this included reference to access to physiotherapy services, routine checks for infection and a six week follow up with a gynaecologist. Prioritising mental health and wellbeing support and services was highlighted by 5.1% of respondents (n=57). Care following a traumatic birth (n=25) and respecting and listening to mothers were also advocated (n=41). Other priorities raised by respondents included accessible information, guidance on infant care, better facilities and access to complementary services.

Table 12: *Priorities for Improvement of Care following the Baby's Birth (Mother)*

	Frequency	%
Breastfeeding support	383	34.6
Postnatal support in the home	119	10.7
Mothers' physical health	106	9.6
Community care by GP and/or PHN	79	7.1
Community midwife	79	7.1
General support	65	5.9
Mental wellbeing support	57	5.1
Adequate staffing	48	4.3
Respect and listen to mothers	41	3.7
Early discharge/ domino scheme	27	2.4
Care following a traumatic birth (physical & mental health)	25	2.3
Accessible information	22	2.0
Continuity and consistency	20	1.8
Guidance on infant care	18	1.6
Better facilities	15	1.4
Access to complementary services	4	0.4
Total	1108	100

3.4.5: Priorities for Improvement of Care following the Baby's Birth (Baby)



Just over half of respondents answered provided a response to priorities for improvement in the postnatal service for babies. Breastfeeding support was also the top priority for postnatal services for children (31.3%, n=235). This included screening for tongue/lip tie, support and education for new mothers, and training for staff (PHNs in particular). A number of respondents suggested that the postnatal support and care for babies should be provided in the home or community by GPs or PHNs (16%, n=130). Some respondents specifically suggested that PHN visits should be weekly up until the baby is 6 weeks old. Others advocated a midwifery-led home service for children during the postnatal period (9.6%, n=79).

A number of respondents stated that enhanced quality of screening of infants during the postnatal period should be prioritised (9.6%, n=79). This includes screening for hip dysplasia, reflux, and jaundice, along with more generally a rigorous assessment of a baby's health at hospital discharge. Others specified that more guidance on caring for a newborn infant should be provided following the birth (6.4%, n=52) and others would like support on promoting parent-child bonding (4%, n=33).

Other priorities listed by respondents included enhanced access to specialised/ hospitals services (in particular paediatricians), advice and access in regard to vaccinations, better neonatal care facilities, standardised, evidence based information/ guidelines, delayed cord clamping, access to perinatal mental health services and continuity of care.

Table 13: *Priorities for Improvement Care following the Baby's Birth (Baby)*

	Frequency	%
Breastfeeding support	235	31.4
Community support PHN and/or GP	130	16.0
Midwifery postnatal home care	107	13.6
Baby exam/ screening	78	9.6
Guidance on infant care	52	6.4
Support to facilitate parent-baby bonding (skin to skin)	33	4.0
General support for parents	33	4.0
Access to specialised services (paediatrician, speech and language etc.)	17	2.1
Respect and listen to parents	17	2.1
Vaccinations	16	2.0
Better neonatal facilities/ transitional care units	13	1.6
Standardised information/ advice	13	1.6
Delayed cord clamping	8	1.0
Other	34	4.2
Total	786	99.6

3.4.6: *Priorities for Improvement of Care following a Loss*



The final section on suggestions for improvements to Irish maternity services focused on care following a loss. In total, 43% of all valid respondents engaged with this question. This lower level of engagement may be reflective of the small number of respondents who have direct experience of bereavement care services.

Greater staff sensitivity and support was highlighted as the main priority for bereavement services or care following a loss (18.8%, n=107). In particular, compassion, empathy and kindness were mentioned by respondents. Furthermore, 5.6% of respondents suggested that staff training on bereavement care is required.

More privacy and better hospital facilities (i.e. a separate ward) for those who have experienced a loss was highlighted by a number of respondents (17.9%, n=102).

In terms of support, a number of respondents would like to see greater access to counselling services (13.7%, n=78), while others suggested specific hospital based bereavement staff should be accessible. Specifically, for some this would be a bereavement specialist midwife. Referral to clinical psychologists, psychiatrists and other specialised services was suggested by 24 respondents. Ten respondents mentioned the role of support groups following a loss. Community and home care was also the preference for 32 respondents.

Table 14: Priorities for Care following a Loss

	Frequency	%
Staff sensitivity and support	107	18.8
Privacy and hospital facilities	102	17.9
Counselling services	78	13.7
Hospital bereavement staff	70	12.3
General support services	66	11.6
Communication and debriefing	41	7.2
Community/ home care	32	5.6
Staff training	32	5.6
Specialised support	24	4.2
Support groups	10	1.8
Continuity and access	7	1.3
Total	569	100

3.5: Suggestions for Service Provision

3.5.1: Promoting Health and Wellbeing

Q. 25: How can the benefits of health and wellbeing for women, babies and their families' best be promoted?

In total 787 respondents supplied an answer to question 25 resulting in approximately 20,000 words of text. These responses were analysed using a thematic framework approach. The main suggestions to emerge from the analysis of this data included:

- ✓ Standardise health promotion advice and information for pregnant women and make it available online.
- ✓ Devise and roll out public health campaigns that promote the benefits of health and wellbeing for women, babies and their families.
- ✓ Adopt a community based approach to health promotion.
- ✓ Provide more and better quality breastfeeding information and education.

These suggestions are outlined in more detail below.

a) Health promotion among pregnant women

Education and targeted health promotion were viewed as the main ways to promote the benefits of health and wellbeing for women, babies and their families. More specifically many respondents suggested that:

- Information should be clear, up to date and evidence based.
- Advice provided by health care professionals should be consistent and not vary depending on the setting or type of provider.
- Training and continued professional development is important for providing accurate and up to date information.
- Standardised guidelines on health and wellbeing during pregnancy should be established.
- Information should be accessible and made available in formats that allow women with sensory disabilities or limited literacy to receive clear advice.
- One to one support was also cited as an effective measure to promote the benefits of health and wellbeing to women.

- Better and more accessible mental health support pre, during and post pregnancy.
- Mutual learning and mentoring from other pregnant women in their locality was recommended particularly for first time mothers.
- Intervene early and provide more preconception care and advice.
- Other suggestions were mother friendly practices, specialist diabetic services and support services, and intercultural services.

b) Public Health Campaigns

Some respondents called for a more general population-based approach through the provision of public health campaigns on issues of diet, physical activity, smoking cessation and responsible alcohol use in the context of planning for pregnancy and during pregnancy itself. Specifically respondents mentioned the following:

- Online formats and social media were highlighted as the most effective way of reaching the target population. Others suggested the use of TV and radio.
- Public campaigns promoting the benefits of breastfeeding and folic acid (less common).
- The first 1000 days campaign.
- Implementation of the Healthy Ireland Strategy (two respondents).
- Targeting of schools and young people on the benefits of a healthy lifestyle.
- Other recommendations included increasing the membership of the Baby Friendly Hospital Initiatives, implementing smoke free policies across all health care settings, and alcohol awareness/ treatment programmes.

c) Community based approach

Many advocated a community based approach to health promotion, facilitated by community midwives, GPs or PHNs. Specifically this approach would involve:

- Running courses or workshops in the community on health related issues in order to raise awareness of the benefits of health and wellbeing for women and their babies.
- Support groups in the community facilitated by healthcare professionals.

- Mentoring and peer support were also advocated.

d) Breastfeeding support and education

Greater efforts to promote the benefits of breastfeeding to women and the public are required according to many respondents. A small number of respondents made specific suggestions including:

- Develop consistent guidelines and training for HCPs on the benefits of breastfeeding.
- Ban all advertising of formula (either in the hospital/healthcare setting or more generally).
- Normalise breastfeeding through public awareness campaigns.

e) Other suggestions

- Facilitate choice of care.
- Ensure continuity and consistency of care.
- Repeal the 8th Amendment.
- Provide women/family centred care.
- Extended maternity leave, paid paternity leave and greater investment into childcare and early years services.
- Workplace support (e.g. educational programmes for employers).
- Information on child development.
- Parenting classes.
- Partner involvement/education.
- Enhance capacity of birth doulas.
- Auxiliary/specialised services including drug dependency services, speech and language therapy, pharmacies.
- Staffing/ hospital facilities.

3.5.2: *Information and Support*

Q. 26: What information and support should be provided to facilitate women and their families to make the most informed decisions on their maternity care?

In total 763 provided a response to question 26, resulting in 21,027 words of text. The main themes and topics raised by respondents were as follows:

- ✓ Provide accessible, clear, consistent and impartial advice on maternity care options.
- ✓ Publish statistics on maternity care services.
- ✓ Make women partners in their care.

a) Clear, consistent and impartial advice/information

The need to provide information in a clear and consistent manner so that women can make informed decisions about their care was advocated by many respondents. Specifically, according to a number of respondents:

- Information should be ‘unbiased’ or impartial i.e. opinions of HCPs should not influence the information women receive.
- Standardised guidance by all HCP (consultant, midwives etc.)
- The benefits, risks and alternatives of each form of care should be clearly outlined. All information and advice should be evidence based.
- Need for initial assessment of risk (high, medium or low risk) and information provided on the most appropriate setting for those specific care needs. This would lead to the development of a personal care plan.

b) Statistics on maternity care

In order to make informed decisions about their care, many respondents suggested that the following information should be made available.

- Statistics on hospital intervention rates (e.g. C-sections, inductions), safety records, complaints, staff- births ratios etc.
- Comparable data on midwifery led care and home birth care.

- Centralised information on hospitals guidelines/ policies (e.g. on VBAC or induction).

c) Women-centred

Women should be partners in their care and given comprehensive information and support on their choices according to many service user respondents.

d) Accessible

Information on type of services should be accessible and readily available. Suggestions to improve accessibility include:

- Centralised online website detailing the care options available and an overview of local services.
- Establish a directory of services and make it available during the initial stages of pregnancy.
- Flow charts and clear diagrams/ infographics were cited as examples of effective ways to display women's care options online/ leaflets.
- GPs are the first point of contact for most women and according to many respondents they need to be better informed on the care options available.
- Cultural awareness of new communities' needs and expectations is required.
- Information should be made available for women with limited literacy or sensory disabilities.

e) Better antenatal services

A number of respondents suggested that information and advice provided during antenatal care needs to be clear, consistent and easily accessible. According to a number of respondents:

- Information on models of care and services should be made available at the initial booking.
- One point of contact for antenatal care to ensure consistency and continuity in information, care and advice.

- Enhanced information on maintaining a healthy lifestyle, breastfeeding and mental health support during antenatal care is required.

f) Other suggestions

- Establish preconception clinics.
- Make information available in schools.
- Role of pharmacists in providing antenatal/ postnatal information.
- Implement tobacco free campuses.
- Health literacy: information is available in non-jargon and an accessible manner.
- Information and services for drug/ alcohol dependent women.
- Information on options for parents receiving a diagnosis of a fatal foetal abnormality.
- Clear and well communicated information in neonatal units.

3.5.3: Model of Maternity Care

Q. 27: What are the key considerations when designing how maternity services are provided (a model of maternity care)?

In total, 746 provided a response to question 27, resulting in 22,765 words of text. The main suggestions raised by respondents were as follows:

- ✓ Facilitate choice and provide more options for maternity care.
- ✓ Implement evidence based policies and practice.
- ✓ Ensure continuity of care.
- ✓ Provide holistic and women-centred care.
- ✓ Maintain a safe and high quality services through investment in staff and resources.
- ✓ Operate services based on equality and accessibility.

A detailed description of these suggestions is outlined below.

a) Facilitate choice

According to a number of respondents, the key consideration for designing how maternity services are provided is to offer options and choice. Specifically:

- Expand midwifery and home birth services to allow women considered low risk to take up these options if that is their preference.
- Provide information on choices available at initial booking of pregnancy.
- Recognise women as partners in their care and acknowledge their needs and wishes.
- Reduce the number of medical interventions and allows women to choose a natural birth.
- Expand community based antenatal and postnatal services.
- Many respondents suggested that the choice of the model of care should be dependent whether women fell into a ‘low risk’ or ‘high risk’ category. Develop midwifery led care as the primary option for women considered low risk. Consultant led care should be the model for women considered high risk.
- Reorient services from a ‘one size fits’ all approach.

b) Evidence based practice

Evidence based care and practice was advocated by many respondents, including:

- NICE and WHO guidelines on maternity care.
- The UK, Australian, Dutch , US, New Zealand care models were mentioned as international maternity care models that could be applied to the Irish context.
- Others pointed to the need to implement cost effective and efficient models of care.

c) Continuity of care

Continuity and consistency were viewed as important elements for a model of maternity care. Specifically, a number of respondents suggested:

- One to one care and assignment of the same consultant/midwife throughout all stages of the pregnancy.
- Continuity of care between settings, i.e. sharing data across health care settings (GP and hospitals). Better integrate community, home and hospital settings.

- Consistency in the care provided across hospitals/health care settings and in the care provided by HCP. Develop and implement standardised maternity care guidelines.
- Ensure continuity and consistency of care through multidisciplinary care and better communication between health care professionals.
- Enhance clinical governance frameworks.
- Facilitate continued professional development.

d) Holistic and women-centred

The health and wellbeing of mother and baby should be central to any model of care according to a number of respondents. In addition, care should be holistic addressing their physical, mental and emotional needs. In addition:

- Deliver care in a respectful manner and afford dignity to all women.
- Listen to women's wishes and needs.
- Ensure informed decision making and consent that recognises women's bodily rights and autonomy.

e) Safety

Safety and quality of service should be ensured by addressing staffing issues and properly resource the service. Specifically:

- Prioritise workforce planning.
- Invest in continued professional and workforce training and development.
- Consistent and evidence based practice to ensure a safe and quality maternity care service.

f) Accessible and Equal

According to a number of respondents, a model of care should encompass the principle of equality.

- Equality in the provision of services between public and private care. Separate private care from public system.

- Equal access to the same models of care regardless of your location, e.g. expansions of midwifery led care, community midwives (Domino) and home birth services to all regions/ localities.
- Expansion of the outreach clinics system to ensure accessible care in rural areas.
- Equality of access and outcomes for vulnerable or socially excluded women including those with disabilities, migrant women, and members of the Travelling community.
- According to a number of organisations equal access to the following services through a community based model should be developed: perinatal psychiatry, specialist nurses for diabetes and epilepsy, women's health physiotherapists, and lactation consultants.

g) Other suggestions

- Integration of mental health services into maternity services.
- A specific model of care for bereavement and loss (Implement forthcoming standards for bereavement care in maternity services).
- Recognition of the social determinants of health.
- Service provision based upon population need and accompanied by the appropriate level of resources. Planning must take into account demographic change and the increasing proportion of complex deliveries.

3.5.4: Safety

Q. 28: What measures can be undertaken to enhance safety within maternity services?

In total, 770 provided a response to question 28, resulting in 17,974 words of text. The key suggestions for providing a safe service according to respondents were as follows:

- ✓ Maintain adequate staffing levels in all maternity care settings and ensure high quality working conditions.
- ✓ Facilitate a transparent and accountable service through clear governance structures, regular audits and patient feedback.
- ✓ Ensure high quality care by providing opportunities for further staff training and continued professional development.

- ✓ Implement national clinical care guidelines and HIQA standards.
- ✓ Make women's needs and wishes central to the delivery of care.
- ✓ Repeal the 8th amendment and the constitutional ban on abortion.

These suggestions are outlined in more detail below.

a) Staffing levels/ working conditions

The main theme to emerge from the question on ways to enhance safety in the maternity services was the need to address staffing levels. Specific recommendations included:

- Lower patient to staff ratios.
- Improve staff recruitment and retention policies.
- Standardise and maintain minimum staffing levels in smaller maternity units.
- Determine current and future demand for maternity services through population needs assessment. Workforce planning based on these needs assessments.
- Improve facilities infrastructure, resources and co-location with acute adult hospital.
- Other staffing suggestions: labour ward consultant cover 24/7, and clinical midwife specialist on all units (bereavement care).

b) Transparency and accountability

Greater transparency and accountability were seen as important factors when ensuring safety in Irish maternity services. Specific suggestions by respondents in relation to this issue included:

- Publish hospital statistics and guidelines.
- Provide opportunities for patient feedback.
- Open transparent reporting of incidents or safety issues.
- Routine standardised audit and review of maternity services locally, and nationally.
- Clear governance structures.
- Open disclosure with supports for patients, staff and families.

- Measure implementation and impact of improved processes following a near miss or adverse event.
- Move away from a ‘blame culture’.

c) Training and professional development

Many respondents pointed to training and continued professional development as central to ensuring staff stay up to date and informed and provide safe, high quality care. Specific HCP training mentioned by organisational respondents included:

- PEWS, IMEWS, Sepsis, obstetric emergency training programme, and handover communication tools such as Situation, Background, Assessment, Recommendation (SBAR).

d) Guidelines and quality assurance

The need to develop and implement national clinical care guidelines was raised by some respondents. More specifically, these respondents suggested:

- Implement NICE guidelines on maternity care.
- Compliance with HIQA standards.
- HIQA inspections and resources to implement recommendations.

e) Women-centred (listen)

Listening to women and their needs was viewed by many respondents as an important component to ensure safe service delivery. Specifically this theme included:

- Reduce the number of interventions and move away from a medicalised model of care for low risk women.
- Facilitate informed decision making.
- Respect women and listen to their wishes.

f) Repeal the 8th amendment

A number of respondents stated that repeal of the 8th amendment is required in order to ensure safety in our maternity services. Specifically, some respondents stated that this would:

- Remove legal uncertainty for healthcare providers when complications arise.
- Provide access to terminations for medical reasons.
- Allow women to access care following a termination in another jurisdiction.
- Facilitate reproductive choice and bodily autonomy.

3.5.5: *Needs Centred Services*

Q. 29: How can we ensure that maternity services are centred around the needs of women, babies and their families?

In total, 725 provided a response to question 29, resulting in 17,614 words of text. The key suggestions outlined by respondents were as follows:

- ✓ Provide opportunities for service user feedback and engagement.
- ✓ Facilitate better communication channels between healthcare professionals and services users.
- ✓ Ensure adequate staffing levels to enable personalised care.
- ✓ Offer more choice.
- ✓ Provide more opportunities for partner involvement.
- ✓ Expand community/home based individualised care.

The main themes and topics raised by respondents are summarised below.

a) Feedback procedures and consultation

Many respondents highlighted the need for better established feedback channels and mechanisms to support and encourage service user involvement in the planning and organisation of services. Once more, there was an overwhelming emphasis placed on the need to listen to women and their families. Specific recommendations included:

- Involve women in the planning of services at a national level (public consultation).
- Develop hospital policy on user involvement and feedback.
- Use feedback forms/ online (postnatal) questionnaire/ local & regional service user forums.

- Deliver care as a collaborative process with women partners.
- Undertake qualitative research with service users (and their families) experiences of maternity services.
- Involve service user representative groups in service planning and hospital committees.

b) Communication between HCP and service users

Respondents reported that better communication between HCPs and service users would ensure that women received care that is centred on their needs. In addition, the interpersonal skills of HCPs and the need to provide care that fosters dignity and respect were also viewed as important for a number of respondents. The need for approachable and highly trained staff was also highlighted.

c) Ensure adequate staffing levels

Many respondents suggested that staffing levels should to be addressed so that a needs centred service can be provided. At present, respondents reported difficulty in providing individualised or personal care due to shortages across the maternity service according to a number of respondents. The issue of staff patient ratios were raised within this context.

d) Offer choice

According to a number of respondents a system that provides choice for women and their families is an important way to ensure that their needs are central to service delivery.

e) Partner involvement

A number of respondents suggested that partner/ father and family involvement should be facilitated by maternity care providers. Fewer restrictions on partner visiting times and the clear communication of issues/ complexities if they arise should be facilitated.

f) Community based care

A number of respondents suggested that the most effective way to ensure a service centred on the needs of women and their families is to adopt a community based approach to care. Further investment and resources are required in order to increase access to community based

services. The advantages of community based care in this regard according to a number of respondents:

- Individualised and one to one care.
- Local accessible services: personalised, familiar surroundings and reduced travel times.

g) Other suggestions

- Special mechanisms to incorporate the feedback of vulnerable women into the design of services.
- Evidence based practice and policies (e.g. midwifery care for low risk women).
- Use maternity data to design services.
- Establishment of birthing centres.
- Repeal the 8th amendment.

3.5.6: Access

<p>Q. 30: How can access to maternity services be facilitated for all women no matter where they live, while making sure that healthcare professionals delivering those services look after sufficient numbers of women and babies to develop and maintain their skills and practice safely?</p>

In total 638 provided a response to question 30, resulting in 18,034 words of text. The key suggestions to emerge from the analysis of question 30 were as follows:

- ✓ Expand community and home based care to ensure greater access to midwifery led services in all geographical locations.
- ✓ Standardise referral pathways and facilitate the integration of services including small and large units as well as pathways between hospital and community settings.
- ✓ Provide more outreach clinics.
- ✓ Practice staff rotation to facilitate the exchange of skills between different units and settings.

The main themes and topics raised by respondents are detailed below.

a) Community, home and midwifery led care

The need to address the inequality in maternity care choices between rural and urban areas was raised by many respondents. For many respondents the expansion of community based services would be the most effective way of addressing geographical inequality in the provision of maternity services. Specific suggestions included:

- Centralise high risk care linked with low risk community based midwifery services.
- Invest in expanded Domino, Early Transfer and other community midwife schemes.
- Shared care between hospital and community services.
- Expand remit of PHN to include antenatal care.
- Facilitate access to home birth through integration of home and hospital with corresponding clinical supervision, and clinical competency opportunities.
- Promote standardisation of practice regardless of location or care setting.
- Other service/model of care suggestions: local midwifery led rapid response teams, local standalone 24/7 midwifery services, more community based perinatal mental health services, establish local birth centres.

b) Referral networks/ pathways and integration of services

- Standardised network of referral between tertiary, regional and local services.
- Clear communication pathway between the hospital and community services.
- A governance structure to include community and hospital services.
- Strong strategic links between large and small maternity hospitals/units (hub and spoke model of care) e.g. a clinical network to be established between small and large units to allow for the transfer of expertise.
- The need to increase the capacity of the ambulance service was suggested by a number of respondents.

c) Outreach clinics

The outreach clinics currently in operation out of a number of maternity units were highlighted as working well. According to a number of respondents this model of care should be expanded to allow for the establishment of outreach clinics for antenatal and postnatal care.

d) Staffing and Training

According to a number of organisations, all health care professionals should be linked with relevant regional services for good governance and ongoing professional development to ensure competencies are maintained and quality of care is provided.

- Rotation of key staff between hospital groups to maintain skills (i.e. experience in specialised maternity settings)
- Rotation of staff from the community to the hospital setting and vice versa.

e) Other suggestions

- Utilise demographic, epidemiological and health service information to maximise the best use of resources.
- Electronic health record to facilitate smoother referrals/transfers.
- Speech and language therapy access via similar hub model used for Communication Learning Program (CLP) in adult services.
- Increase the capacity of birth doulas.
- For babies transferred for longer-term intensive care, the networks should facilitate early return to the local maternity unit when the baby is recovering.
- Hub and spoke laboratory model.
- Greater partnership at a local level between drug and alcohol services, children's health and social care services and maternity services.

3.5.7: Views on Appropriate Setting for each Stage of Maternity Care

Question 31 sought to gather respondents' views on the most appropriate setting for each of the stages of maternity care outlined below. This was open to all those who completed section 2 (n=1050). This question is multiple response, allowing respondents to choose more than one setting for each stage of care.

Q. 31: What setting(s) would you consider to be the most appropriate for the following stages of care?

- a) Advice and care on getting pregnant (up to 3 months before conception)
- b) Care during pregnancy (antenatal care)
- c) Care during labour (intrapartum care)
- d) Care following baby's birth (up to 6 weeks after birth)
- e) Care for those who have experienced a loss

For each of the above respondents were asked to choose the following options a) hospital, b) community, c) home and d) other.

a) Advice and care on getting pregnant

Table 15 shows that almost half of respondents (48%, n=499) would view the community as the most appropriate setting for preconception care. A further 18.8% selected the combination of home and community for their preconception care and 7% chose home only.

b) Care during pregnancy

There was a wide variety of preferences in relation to antenatal care. One fifth indicated that the community would be the most appropriate setting for antenatal care and a further 18.8% indicated that a combination of community and home care would be preferable. In total, 88 respondents indicated that a home based antenatal service would be most appropriate and 15.7% (n=165) stated that a combination of hospital, home and the community would be preferable. Just 9.2% (n=97) of respondents stated a preference for hospital only antenatal care. In addition, just 10 respondents indicated that the combination of home and hospital care is most appropriate during the antenatal stage.

c) Care during pregnancy

In total, 28.8% of respondents suggested that the hospital is the most appropriate setting for intrapartum care. A number of respondents (9.7%, n=102) indicated that the home only is the most appropriate setting intrapartum care. This was in conjunction with those who had a preference for a combination of hospital and home (15.4%, n=72) or hospital, community and home (18.4%, =193) or home and community (6.9%, n=72).

d) Care following the baby's birth

In relation to postnatal care there was a wide variety of responses, but most respondents indicated that the home is the most appropriate setting, either on its own (25.5%) or in conjunction with the community (26.1%), or the hospital and community (16.2%) setting.

e) Care for those who have experienced a loss

There was significant variation in respondents' views of the most appropriate setting for care for those who had experienced a loss. For approximately 60% of respondents, home would be the most appropriate setting for this type of care, either in conjunction with community (23.2%) or hospital community services (21.2%).

Table 15: Type of Care by Ideal Setting (All Respondents)

	Advice and care on getting pregnant		Care during pregnancy		Care during labour		Care following the baby's birth		Care following a loss	
	N	%	N	%	N	%	N	%	N	%
Hospital Only	18	1.7	96	9.2	301	28.7	30	2.9	44	4.3
Community only	499	48.1	215	20.5	26	2.5	144	13.8	107	10.6
Home only	73	7.0	88	8.4	102	9.7	267	25.5	190	18.7
Other	48	4.6	9	0.9	17	1.6	10	1.0	30	3.0
Hospital, Community & Home	31	3.0	165	15.7	193	18.4	170	16.2	214	21.1
Hospital & Community	45	4.3	183	17.5	87	8.3	52	5.0	53	5.2
Hospital & Home	2	0.2	10	1.0	161	15.4	25	2.4	39	3.8
Home & Community	194	18.7	198	18.9	72	6.9	274	26.2	235	23.2
Other combined care	128	12.3	84	8.0	89	8.5	75	7.2	102	10.1
Total valid	1038	100	1048	100	1048	100	1047	100	1014	100
No answer provided	12		2		2		3		36	

3.5.8: Comparisons between Care Received and Care Preferences

Table 16 directly compares service users' reported care setting (i.e. where they actually received their maternity care as outlined in Table 7) to their preferences for maternity care setting. In Table 16 the first column is the services users' reports on the type of care they received. The second column is distribution on type of care preferences based on service users responses only (n=775) to question 31. In total, 243 service user respondents did not complete question 31 therefore the sample sizes differ significantly. In addition, it is not possible to make comparisons for preconception care or care following a loss as the majority of service user respondents selected not applicable for question 14 (table 7). While these issues limit what can be extracted from the results, the comparison is interesting nonetheless.

In total, 11% of service user respondents had a preference for hospital only antenatal care. This is in contrast to the care service user respondents actually received, whereby 38.9% received antenatal care in the hospital setting. However, a further 32.9% stated a preference for hospital care in conjunction with the community and/or home setting. Thus, reflecting a preference for combined care during pregnancy.

Differences in actual care received and care preferences were also found for intrapartum care. For example, 77.2% of service user respondents reported that the hospital was the only setting they received intrapartum care (see column 3, table 16). This is compared to 30.2% who had a preference for hospital only care. However, as with stated preferences for antenatal care, a further 40% would like the hospital to form part of their care in conjunction with the community and/or home setting. Similarly, while the percentages reporting home only care is largely similar for actual care received (11.5%) and preferences (11.7%), a high proportion of respondents indicates that they would like the home to form some part of their intrapartum care (51% in total). These preferences may be a reflection of recommendations for greater integration of home, community and hospital care in regard to the provision of intrapartum care services.

With regard to postnatal care the preference figures were largely comparable with the type of care service user respondents actually received, with a higher number reporting a preference for home based postnatal care.

Table 16: Comparisons of Actual and Ideal Care Setting (Service User Respondents Only)

	Care during pregnancy		Care during labour		Care following the birth	
	Actual %	Preference %	Actual %	Preference %	Actual %	Preference %
Not applicable	0.3		2.6		2.9	
Hospital Only	38.9	11.0	77.2	30.2	9.0	3.2
Community only	9.0	20.3	0.5	2.5	26.9	14.0
Home only	6.2	9.7	11.5	11.7	17.9	27.9
Other	2.4	0.5	0.5	0.9	2.8	0.9
Hospital, Community & Home	3.2	12.7	0.2	19.1	9.3	14.1
Hospital & Community	29.0	18.9	2.7	8.3	15.0	5.4
Hospital & Home	3.1	1.3	3.1	13.4	3.9	2.5
Home & Community	1.6	19.0	0.4	7.7	8.6	26.1
Other combined care	6.3	6.7	1.4	6.2	3.9	5.9
Total valid responses	1010	774	1008	775	1005	774

3.6: Workforce and Governance

The key suggestions for the workforce planning resulting from the analysis of questions 32 and 33 were:

- ✓ Incentivise opportunities for continued professional development.
- ✓ Invest in the services and ensure adequate staffing levels.
- ✓ Increase the capacity of midwives and midwifery led services.
- ✓ Maintain quality care through supportive and encouraging staff appraisals.
- ✓ Address issues of staff hierarchies and bullying.
- ✓ Support and develop multidisciplinary teamwork through interdisciplinary education sessions, electronic records, team building exercises, and formalised structures.

Q. 32: How can the full potential and capabilities of all healthcare workers within maternity care be realised?

In total 716 provided a response to question 32, resulting in 17,985 words of text. The main themes and topics raised by respondents are summarised below.

a) Training/ CPD

The importance of training and continued professional development for staff was highlighted as the main way to ensure that full potential and capabilities of all healthcare workers are realised. Many respondents suggested that staff should be afforded time to re-train and that training and education schemes should be incentivised. International best practice for CPD and the importance of evidence based training were also emphasised. In addition, the following were raised in relation to training:

- Recognise and build upon existing staff skills sets and support and encourage interests of staff.
- Train on the important and influential role of psychological processes in the pregnancy, perinatal, postnatal and early years with regard to optimal outcomes.
- Provide training from specialists (e.g. perinatal mental health midwife) to multidisciplinary groups to increase their skill and knowledge base.
- Breastfeeding training.
- Mentoring/ peer learning.

- Staff rotations: equal opportunity to experience provision of low and high risk care e.g. rotational/clinical placements via hospital group structures.
- Equal access to CPD/ studying/ development for all disciplines.
- Development of career pathways for midwives: e.g. routes into clinical midwife specialists and advanced midwife practitioners roles.

b) Adequate staffing levels and resources

Improvement of basic working conditions and the importance of fostering a healthy working environment also emerged as a key theme from the analysis of responses in relation to question 32. Specifically respondents highlighted the following:

- Better pay and working conditions.
- Lower patient-staff ratios.
- Support, respect and value staff.
- Well defined roles and governance structures.
- Caseload model for midwifery care.
- Less paperwork and move toward electronic records.
- Development of an agreed national staffing model for midwifery and nursing.

c) Expand and increase capacity of midwives

A number of respondents suggested that expanding the remit and increasing the capacity of midwives would be beneficial. In particular:

- Utilise midwives for low risk pregnancies.
- More delegation from consultants to midwives.
- Empower midwives and enable an autonomous midwifery service.

d) Performance appraisals and feedback

The requirement for supportive and encouraging staff performance reviews was identified as another method of realising the capabilities of staff. Specifically respondents highlighted the following:

- Service user feedback.

- Peer review.
- Engagement of all healthcare professionals in the planning of services.
- Effective clinical and organisational governance with constant attention to identifying issues, gaps, safety concern.
- Involvement of user/ patient advocacy groups.

e) Culture and staff hierarchy

A number of respondents suggested that staff hierarchy and stereotypes were barriers to multidisciplinary work. This was felt to impact negatively on the potential and capabilities of some staff. In order to have a more positive and equitable environment the following were recommended:

- Better communication
- No blame culture
- Zero tolerance for bullying

f) Other suggestions

- Training for all HCPs caring for women with addiction or mental health issues. Implement WHO guidelines for the management of substance use in pregnancy.
- Limit the use of locum midwives and Non-Consultant Hospital Doctors
- HCPs act as ‘health and wellbeing agents’.
- Official grading of staff similar to UK system, i.e. Grade D, E, F, G, with specific competencies for each grade.
- Reflective practice and healthcare workers awareness of their own emotional wellbeing needs. Resources are required to support healthcare workers to attain high levels of emotional wellbeing and resilience.
- Expand pharmacists role in the delivery of maternity care (preconception, antenatal and postnatal care and advice).
- Need for improved interface between GP and neonatal services.

Q. 33: How can teamwork between healthcare workers be enhanced, both within their own disciplines and across disciplines?

In total 623 provided a response to question 33, resulting in 13,189 words of text. The main themes and topics raised by respondents are summarised below.

a) Communication and multidisciplinary team work

The importance of effective communication between HCP professionals was the main theme to emerge from the analysis of question 33. The need to have integrated services (i.e. community, home and acute services) and better multidisciplinary team work focused on the needs of women and their families was advocated by most respondents. Specific suggestions in regard to MDT work and communication included:

- Clearly defined roles and governance structures.
- Feedback and debriefing opportunities for staff i.e. offered opportunities to express concern within team.
- Open disclosure and transparency and support from senior management if an incident occurs.
- MDT meetings and clinical discussions.
- Team building exercises.
- Enhance the capacity of midwives (more trust). Midwifery led care for low risk pregnancies.
- Implement handover guidelines.
- Mutual respect i.e. all professionals are seen as equal but complementary. Acceptance of and respect for roles and responsibilities within the team.
- Breakdown hierarchy in hospital settings and divide between consultants and midwives.
- Measure to support communication and multidisciplinary team work between hospitals and community settings (i.e. community HCP, G.P. and PHNs).
- Established referral pathways between hospital based and community services (e.g. NICE referral protocols).

b) Training/education and professional development

Equal access to professional development programmes both within the discipline and across disciplines was viewed by a number of respondents as an important element of multidisciplinary team work. In addition the following suggestions were made:

- Cross training and knowledge sharing across disciplines.
- Interdisciplinary education sessions: in house or between hospital groups.
- Earlier interdisciplinary education. For example, joint classes between medical and nursing students at undergraduate level.
- Joint/ interdisciplinary research.
- Multidisciplinary training.
- Support and mentoring of student nurses/midwives.

c) Staffing/ working conditions

- Ensure adequate staffing levels.
- Foster a healthy/positive work environment.
- Address incidents of bullying/ zero tolerance for bullying.

d) Common and accessible health care record

Computerised records were advocated by a number of respondents. Specific suggestions included:

- A single national health database linking all patient records.
- Establishment of a system to transfer records from GP to hospital setting.
- Central hub where teams can consider casework and evaluate appropriate interventions.

e) Other suggestions

- For specialised needs greater links with social and community/voluntary services, eg. drug and alcohol services, bereavement support groups.
- Need for a multidisciplinary bereavement specialist team.
- Establish interdisciplinary sub groups to work on a particular area.
- Treatment and care for pregnant drug users: coordinated, multidisciplinary interventions encompassing prevention, screening and treatment of infectious

diseases; mental health; personal and social welfare; gynaecological/obstetric care.

- Role of birth doulas/ greater recognition in maternity services.
- Complementary services such as homeopathy.
- Integration of pharmacists into maternity services.

<p>Q. 34: How can we ensure that best practice is applied consistently across all services providing maternity care?</p>

In total 679 provided a response to question 34, resulting in 12,206 words of text. The key suggestions resulting from the analysis of questions 34 and 35 were:

- ✓ Standardise systems for regular audits and reviews of practice, including independent public inspections.
- ✓ Develop and implement national guidelines on maternity care.
- ✓ Establish and standardise clear governance structures to ensure accountability and transparency.

The main themes and topics raised by respondents are summarised below.

a) Audit and Review

In order to ensure that the same standards of care are applied across the maternity service, many respondents suggested that audit and regular reviews of practice be carried out frequently. In particular, some respondents highlighted the need for specific type of review including:

- Independent evaluations,
- External inspections,
- Monitoring bodies/structures peer review.
- Patient/user feedback (survey/ focus groups), benchmarking.

b) National Guidelines

According to a number of respondents national guidelines that can be applied across different hospitals and settings should be developed and implemented. The following elements should be taken into consideration:

- National Quality Standards.
- National Clinical Guidelines.
- Any guidelines should be clear and consistent.
- They should be evidence based (e.g. NICE guidelines) or following international best practice (e.g. UK or Australian models).
- Standardise across all hospitals and settings.
- Need for structures and resources to implement guidelines.
- In regard to mental health adhering to guidelines and recommendations laid out in Vision for Change and NICE .

c) Accountability and transparency

Clear governance structures encompassing leadership, good governance and oversight were viewed as the main ways to ensure accountability and transparency. Specific suggestions included:

- Produce transparent reports on the state of maternity care in line with agreed quality standards (e.g. via HIQA).
- Publish maternity care statistics.
- Publish hospital guidelines.
- ‘No blame culture’.

d) Staffing

- Adequate level of staff.
- Access to training and education.
- Continued professional development.

e) Other suggestions

- Repeal 8th amendment.
- Implement breastfeeding policies.
- Two tiered health system leads to poor outcomes.
- Better governance in neonatal units.

Q. 35: How can governance* of maternity services be improved?
*Essentially how services are led, managed and monitored

In total 608 provided a response to question 35, resulting in 14,234 words of text. The main themes and topics raised by respondents are summarised below.

a) Governance structure, accountability and transparency

In order to facilitate good governance; accountability and transparency must be promoted according to a number of respondents. For most this requires a clear management structure in all units and settings. According to a number of respondents a central maternity governance system is required to ensure integrated governance across all maternity services, including regular, inter-professional audit and review of adherence to best practice standards. Specific recommendations include:

- Clearer reporting structures.
- Open disclosure and clear communication channels.
- Lead clinician role clearly identified.
- Director of midwifery as part of senior management team.
- Expansion of the Voluntary Hospital Governance Structure of Boards/Executive Management Team.
- Ensure existing governance structures are not diluted through the establishment of hospital groups.
- Hub and spoke model for linking national, regional and local services.
- Establish Network Committee or National Integrated Maternity Services Governance Group.
- Develop management protocol as per the NICE guidelines.

- In relation to midwives specifically, the appointment of a national supervisor/director of midwives spanning acute, primary and community services and not restricted to HSE employed midwives is required.
- Reinforce the importance of effective governance in staff culture.

b) Independent and public audits

- Establish standardised monitoring and evaluation framework (e.g. Key Performance Indicators (KPIs), metrics, and benchmarking).
- Frequent reviews of practice.
- Clinical audit, independent inspections, confidential enquiries and evaluations.
- Transparent adverse events reviews.
- Patient experience surveys.
- Robust reliable process/information system.
- Financial/budgeting accountability is tied to clinical governance outcomes.
- Develop a data system to conduct audits for practice development.
- Involvement of user/ patient advocacy groups.

c) Staffing levels/ working conditions

- Ensure adequate staffing levels.
- Listen and respect staff

d) Other suggestions

- Clinical guidelines for the management of substance use in pregnancy must be developed.
- Clarify governance of home birth services.
- Need specialised governance structure for breastfeeding (i.e. a hospital breastfeeding lead).
- Establishing the discipline of psychology within the management structure and clinical leads of maternity services supports international best practice, good governance and appropriate service provision to women, infants and their families within Irish maternity services.

Q. 36: Is there anything else you would like to add?

In total 643 respondents provided a response to question 36, resulting in approximately 54,000 words of free text. Most respondents used this section of the consultation document to express their core concerns, issues and suggestions. The main issues identified (in order of frequency) are outlined below.

a) Normalising of birth

Reorienting maternity services away from a medicalised model and towards a more natural process was a strong theme. Normalised birth also featured across several other topics including home/community care, role of the midwife and women-centred care. Educating and empowering women about the normality of birth was advocated by both service users and maternity services staff. Service users in particular commented on a ‘culture of fear’ and childbirth being treated as a medical condition.

Birth is not an illness, our bodies are not broken. Birth is normal, ordinary and safe for the majority (Service user)

Starting from a base of trying to normalise childbirth might be a way to frame the strategy process and influence how standards are written (Healthcare professional)

Appropriate care for appropriate risk was advocated with medical intervention not seen as the norm.

Hospital services are wonderful for emergencies cases but the way we are setting our services up, we are creating the emergency situations by intervening too early, too frequently and without need (Service user)

b) Women-centred care

Many respondents advocated for women to be placed at the centre of care or conversely cited examples of where hospital culture, staff attitude and ‘outdated policies’ were prioritised over the needs of women. Closely linked with this theme were a desire for greater choice, better communication, more breastfeeding support and an expanded role for midwives and home/community care. Many respondents spoke of having no voice or control over their care. Others identified a need to trust and listen to women.

Woman-led care - where women are provided with transparent, evidence-based, unbiased information with which to make informed decisions - is the only option for a modern, safe and well-functioning maternity service. In the vast majority of cases, women will always choose the safest and best options for themselves and their babies. Our current maternity system does not recognise this and instead adopts a prescriptive model where women are often in the first instance unaware of options available to them; and in the second instance denied evidence-based care in favour of local hospital policies. We need to trust women - to make their personal informed choices and at the same time make informed refusal if that is their wish. Women are the experts in their own bodies and babies. A maternity system should support this fact, not undermine it (Service user)

c) Choice and access to a broader range of birth options

This broad category includes both a general lack of availability of options and inconsistencies and inequities in distribution of available options, largely from a geographical perspective but also from a cost/affordability one. Increased availability of broader range of birth options, in particular more community based services was a recurrent theme.

A national maternity strategy should have choice at the heart of it (Service user)

The country needs to move away from the medical model of maternity care for low risk mums & babies & facilitate more choice in alternative care models there also needs to be a more holistic approach, taking into account this emotional & psychological needs of parents & babies - before & afterbirth (Service user)

While community based services were frequently cited, others spoke about the availability of choice and appropriate care for appropriate risk.

Having a baby is a very personal and private affair and each woman knows what is best for her and her baby. No one size fits all women and their families should have the option of deciding which service is most appropriate for her and her family's needs be that obstetric led or midwife led or sometimes a combination of both. Women and their families just want a choice (Healthcare professional - Community midwife)

The role of the midwife was seen as a core feature of increasing the range of maternity services including more midwifery led units and home/community services as well as better utilisation of skills within hospitals.

All current research and guidelines advocate midwifery led care for low risk women as the most efficient way to improve maternal and foetal/infant wellbeing. We have to stop paying lip service to it and start developing these services. We already have

templates for Homebirth, DOMINO care and MLUs in Ireland (Healthcare professional)

Geographical location, both in terms of access to hospitals and eligibility for existing community services was perceived as inequitable. Geographic distribution of services was highlighted as an issue both from people in rural areas to those living just outside catchment areas for particular services.

The National Maternity Strategy should standardise maternity services to enable women to have a high standard of maternity care in all areas of the country with the same services available (Healthcare professional)

d) Safety, Quality and Continuity of care

This covers a range of topics including culture and staff attitude, postnatal care and evidence based care. Its main focus is on hospital based services as these formed the majority of comments. It is closely linked with the theme of availability of support services and many respondents acknowledged the impact of limited resources on the quality of care received. The impact of both positive and negative staff attitudes on their experience was described by some service users.

I would just like to emphasise that listening to women and making them feel safe and looked after emotionally throughout is simply about a shift in awareness, not more funds and I fundamentally believe it will save you money down the line. I was really scarred by my experience of giving birth in Ireland. The lack of care I received and frankly medical neglect has left me afraid to have any more babies in this country. That is not the way it is supposed to be in a developed country like Ireland known for its kindness and strong moral values (Service user)

My experience of maternity services in Ireland was a very positive one and in my time using the services I was cared for by a number of fantastic doctors and midwives (Service user)

Others attributed their negative experience to a general hospital culture or system.

I strongly believe that administration and meeting targets are negatively affecting the role of midwives. While I am not a midwife, I observed that midwives hands were tied by management structures and rules and they cannot effectively care for their patients because 'boxes need to be ticked'. While some systems need to be in place, there is a big issue when patients are not adequately carried for because of box ticking exercises (Service user)

Others highlighted the potential of health promotion and continuity of care at this point.

The maternity services are about more than delivering a live baby to a live mother, though of course it should at least do this. It offers a unique opportunity to make a positive health intervention in the health of an individual mother/father/baby/family and in the health of the nation. A good model of continuity of care is needed, where the mother's dignity and wellbeing is respected and she feels more than a unit on an assembly line, a model which supports her and her new family beyond 24/48 hours post-birth (Service user).

e) Availability of support services

This overarching theme draws mainly on issues related to breastfeeding support, mental wellbeing and bereavement care. Some of the issues are closely linked with those identified in quality of care.

Staff knowledge around breastfeeding was seen as insufficient in general and inconsistent. Respondents also commented on a perceived conflict of interest between being supportive of breastfeeding on the one hand while at the same time having formula freely available in hospitals.

I find the service so unsupportive generally to breastfeeding. It undermines the ability of each woman and pays mere lip service to the breast is best message. It leaves women disillusioned, traumatised and feeling guilty (Service user)

A lack of psychological support services was highlighted as well as general knowledge of issues such as PND.

I think that for women experiencing mental health issues there is a lack of understanding of their needs. I suggest that greater choice of maternity care models and the meaningful inclusion of service user input is required at local and national levels if a maternity service is to be developed to meet the needs of this group of women and their families (Healthcare professional)

Urgent need to address perinatal mental health and develop a service that is available irrespective of post code, currently few perinatal psychiatrists or comprehensive services and supports available to women, who have a prior mental health issue or those who develop issues during pregnancy or in the postnatal period. Mental health issues are more than depression, need to consider anxiety, eating disorder, PTSD, phobias, substance misuse and psychosis (Organisation)

f) Better resources/ Investment in staff and facilities

Lack of adequate staffing in particular postnatally was seen as a problem for many respondents.

I have never had an issue during childbirth but post delivery women and babies are not given enough care. The staff are simply not there to do so. As a first time mother it is not a pleasant experience (Service user)

Outdated facilities and practices were also highlighted.

The barriers we face are purely due to budgetary restrictions which impact on staff and infrastructural resources on a daily basis. We have a motivated workforce, who are unfortunately demoralised by the outdated clinical environments in which many of us work and the serious staff shortages not just in obstetric services but also in allied specialties (Healthcare professional)

Section 4: Summary of Focus Group Findings

4.1: Introduction

The Department of Health held and reported on two focus groups to supplement the online consultation questionnaire in order to ensure that a range of experiences and perspectives would inform the development of the strategy. The focus groups took place in Cork on 15 July and in Dublin on 20 July. The Chair of the National Maternity Strategy Steering Group attended both sessions. Participants were organised by the National Women's Council of Ireland, and included a mix of individuals and organisations representing varying interests, such as those relating to; women and family groups, pregnancy related advice and support groups, domestic violence support groups, women who experienced a loss, and migrant Traveller and Roma populations.

4.2: Findings

At these groups participants shared both positive and negative experiences of Irish maternity services. Some participants were able to make comparisons between experience of different pregnancies, maternity services abroad, and across settings and time. In addition, some participants were able to contrast their experiences and perspectives as both service users and healthcare professionals.

The following ten themes emerged from the experiences shared by the participants.

a) Information: “an informed woman is an empowered woman”

- Women want appropriate and timely access to clear and user friendly information.

The type of information sought includes:

- What to expect at every visit, especially the questions asked at booking visits.
- Type of care available.
- Entitlements and private options for care not provided as part of a standard care model.
- Which diagnostic tests are used and why.
- Regulations such as those relating to birth registration etc.
- Clinical information: rapid labour, postnatal depression, and miscarriage (physical and emotional aspects, treatment options).
- Support and advice on postnatal tiredness.

- Effect of childbirth and postnatal experiences on libido and relationships.
- Leaflets should support, not serve as the only, communication.
- HSE and individual hospital websites are not user friendly for information searching. Women and their families use social media and parenting forums for further information.
- GPs could provide more education, especially pre-pregnancy care for mothers and fathers.

Suggestion

- ✓ Establish a one-stop shop information resource for all pregnancy related information and services. Make the information available in a number of languages and formats (text, audio-visual and pictorial).

b) Culture and attitudes

- The service is viewed as being hierarchical, and consultants do not always interact directly with women.
- Some women have difficulties in communicating openly with male consultants.
- Some women reported difficulties in accessing the reasons for decisions made in situations when consultants disagreed with them on the management of their care.
- There are also some exemplar staff working in the maternity services– those that did “small things, like hold my hand”.
- Specific groups, such as Travellers, reported feeling stigmatised, which made them reluctant to engage with services for future pregnancies. Positive experiences were also reported.
- Women are not always included in the decision-making process. Sometimes they are not informed of a procedure, and, consequently, consent is not always sought prior to a procedure being carried out, particularly when they are at their most vulnerable. Interventions to speed up labour were specifically mentioned in this context.
- The service primarily focuses on the baby – it should acknowledge mother and baby as a unit.

- Litigation-driven processes are demeaning and de-valuing, whereas a woman-centred approach, that respects women's choices and birth plans where possible, creates a positive experience.
- Migrant women like the free service, epidural availability, equal treatment, lack of racism and efficiency, but noted the need for cultural awareness training. Undocumented residents, with no PPSN, fear having to pay for services and their baby being taken from them because of their status, with some limiting their interaction with the service as a result.

Suggestions

- ✓ Involve women and their families in the management of their care – view them as partners along with healthcare professionals.
- ✓ Facilitate feedback/de-briefing after each birth. This will assist women in understanding why the birth may not have proceeded according to their initial plan, and allow for any necessary follow-up referrals. Feedback mechanisms will allow the system to evaluate its performance and inform future service provision by the perspectives of women and their families.
- ✓ Care for, and communicate with, all women in a culturally sensitive manner.

c) Staff Interaction: 'Do staff realise the impact they have?'

- The interpersonal skills of healthcare professionals is very important, as poor performance in this regard can mean that staff can appear to be rude or insensitive. For example, the label 'Traveller' and not the care requirement, was put on a cot to ensure appropriate feeding in the context of a metabolic disorder. Unwell mothers were told to change nappies themselves on the postnatal ward, even if they were weak or distressed and unable to do so.
- Greater focus is needed on partners/fathers in all care models and pathways, as in some cases they are made to feel in the way.
- Women reported a reluctance to use complaint services in case of possible repercussions in future dealings with the service.
- There is a clinical culture of 'busyness', with parents not wishing to disturb staff to ask questions or get physical checks. In addition, some interventions are seen as standardised, rather than for individual needs.

Suggestions

- ✓ Communicate clearly and sensitively with women and their families.
- ✓ Tailor care and services appropriately to each individual woman and family's needs.
- ✓ Establish service user feedback mechanisms.

d) Models of care

- Domino schemes and home births work well, especially where midwives transfer with the mother when problems arise in labour, for continuity of care. These services:
 - Give personalised care with time to talk and address fears.
 - Empower women in terms of joint decision-making processes.
 - Expedite access to services.
 - Afford better continuity of care.
- Other suggested models include midwife-led units and 'case-load' midwifery for continuity of care, with both options continuing the shared care arrangement with the GP.
- Maternal mental health is not prioritised across the pathway and some services, such as psychiatric liaison, are not nationwide.
- Services are not joined up and lack timely information sharing. This can mean that women often have to repeat the same conversations with numerous healthcare professionals, which can be particularly distressing when it involves a traumatic experience.

Suggestions

- ✓ Expand the range of care options across the country.
- ✓ Improve data collection processes and sharing of information across service providers.
- ✓ Develop clear referral pathways to other services.

e) The Clinic: ‘like cattle - check, prod, go’

- The absence of dedicated appointment times in antenatal clinics means long waiting times. Women are called by number, not name, and waiting room capacity is inadequate, especially chairs.
- There is no continuity of care in clinics, with different staff at each visit.
- Migrant women cited access issues because of their employers’ reluctance to facilitate their attendance at appointments.

Suggestions:

- ✓ Allocate specific appointment times.
- ✓ Improve waiting room facilities.

f) Breastfeeding

- Cultural attitudes in Ireland do not support women to establish and continue breastfeeding.
- While staff attitudes vary, generally it was felt that hospital staff do not encourage breastfeeding from birth. This is exacerbated by the ready provision of infant formula in the hospital, giving the impression that bottle feeding is easier for staff.
- Postnatal demonstrations/classes are given on bathing, nappy changing and bottle feeding, but not breastfeeding.
- All midwives need training in breastfeeding support, as lactation consultants are not always available (weekends, baby in Special Care Baby Unit etc.) or for limited times. Promotion of breastfeeding to Travellers was also raised.

Suggestions:

- ✓ Improve breastfeeding support for expectant and new mothers.
- ✓ Improve breastfeeding training for all staff involved in antenatal and postnatal care.

g) Getting home

- The transition from hospital to home can be challenging. Women should be discharged when they are ready, and hospital and community postnatal support and resources should be improved.
- New motherhood is isolating without wider family support. Some women found that the Public Health Nurse service focused only the baby, there were too few visits and no telephone support. Others reported the 6 weeks postnatal check-up at the GP also focused only on the baby, instead of the expected mother and baby examination. The Domino and home birth postnatal service work well. Some PHNs provided excellent postnatal care, and put women in contact with other new mothers in the local area.
- More community postnatal services are needed, including home visits, especially in rural areas where transport is a challenge.
- Paid maternity leave is short, and migrant women often can't take unpaid leave – some participants suggested 12 months paid maternity leave, and 4 weeks paternity leave.

Suggestions

- ✓ Enhance the postnatal service across all models of care.
- ✓ Look at maternity and paternity leave arrangements.
- ✓ Consider mechanisms that could allow women to connect with other mothers – this could include on-line resources, especially for those living in rural areas.

h) Separation and loss

- A loss can provoke anxiety in subsequent experiences. Bereavement services are improving, but standards differ around the country.
- Staff in units deal with loss (early pregnancy loss, foetal assessment units) sensitively. More mainstream staff can lack empathy and not all services show understanding.
- Facilities for private conversations do not exist. There are difficulties for families experiencing early pregnancy loss in terms of being alongside

pregnant women or mothers, and women suggested a physical separation of services.

- Other than GPs, there is little primary care support in early pregnancy loss or awareness of support groups.
- When it is necessary to treat the mother and baby separately, better communication and support is needed to avoid late or non-bonding. Location of wards and SCBUs should be considered in hospital layouts.

Suggestions

- ✓ Increase access to bereavement supports in all maternity services.
- ✓ Ensure that news relating to a loss is conveyed in a private and quiet setting, or apologise for the unsuitable setting when this is not possible.
- ✓ Adopt an individualised approach to care, particularly when the mother and/or baby require an enhanced level of care.

i) Evidence based care

- Greater evidence-based practice in the maternity service is needed, such as NICE guidelines.
- Without standardised care, women do not feel safe, although negative media coverage is acknowledged in this issue.
- Identified best practice does not always occur. For example, a ‘train the trainer’ programme in domestic violence recommends screening without the partner, but this doesn’t always happen.
- More transparent data and analytics for monitoring maternity services are needed. For example, ethnicity data should be included in booking visits, to improve information on maternity service users. Also, models and infrastructure elsewhere should be examined.

Suggestions:

- ✓ Standardise evidence-based care across the country.
- ✓ Improve data collection and audit systems.

j) Doing it for themselves

- Where there are gaps or weaknesses in services, women tend to fill them in themselves through voluntary groups. Health professionals, such as PHNs or Traveller health advisors, also direct women to these groups for practical support. While this is viewed as a positive addition, they are not available across the country. Not all service users are aware of the availability or types of service offered.

Suggestion:

- ✓ Provide information about voluntary and community support groups.

Section 5: Key Findings

There are number of key issues that were frequently raised across all aspects of the consultation. Therefore it is possible to highlight areas where there was a great deal of consensus among consultation respondents which would form priority cross-cutting issues in the development of the National Maternity Strategy. As already outlined in section 1, respondents are self-selecting and as such may not be representative of public opinion.

High level service planning:

- Facilitate choice of care (hospital, community, home) and make options available to service users regardless of their geographical location or ability to pay.
- Increase the capacity of midwifery led services for women categorised as a low risk. Expand access to the Domino Scheme, Early Transfer Schemes and Home Birth Services. Establish more Midwifery Led Hospital Units. Integrate home birth services with hospital services.
- Enable smooth transition of care between services through a centralised electronic service user record.
- Reduce antenatal clinic waiting times by improving the appointment system and increasing the capacity of midwifery clinics and/or outreach clinics.
- Promote the benefits of health and wellbeing for women and their babies through online campaigns and information services. Establish standardised preconception and antenatal health and wellbeing guidelines.
- Invest in and develop postnatal services in the hospital, community and home setting.
- Implement the HSE Breastfeeding Action Plan and the Baby Friendly Hospital Initiative.

High level service quality and safety:

- Maintain adequate levels of staffing and resources. Implement workforce planning following an appropriate needs assessment. Relieve pressure on hospitals by providing more care in the community.

- Ensure continuity of care between healthcare settings and across healthcare professionals. Facilitate where possible access to the same healthcare provider at each stage of care.
- Develop and implement evidence based standardised maternity care guidelines (e.g. NICE).
- Improve communication skills of HCP and improve mechanisms for multidisciplinary team work.
- Audit, review and ensure transparency. Publish statistics on maternity care for all settings and provide information on hospital guidelines to service users.
- Improve postnatal care in the community and hospital settings by increasing the capacity of GPs and PHNs.

Management of labour:

- Provide women-centred care and ensure that women's needs and wishes are listened to and that they are afforded dignity and respect through all stages of their intrapartum care.
- Provide the option of a natural birth by reducing the number of medical interventions in the hospital setting. Facilitate informed consent and shared decision making at all stage of intrapartum care.

Support services

- Provide more and better quality breastfeeding support in the hospital, community and home setting. Support should include information and advice during the antenatal period, access to lactation consultants, tongue tie checks at hospital discharge, training for PHNs on providing breastfeeding support, reduce infant formula top ups and increase staff on postnatal wards.
- Integrate mental health and wellbeing support services across all elements of maternity services.
- Establish hospital bereavement teams and implement the forthcoming HSE bereavement care standards.

References

Central Statistics Office (2011) CSO Boundary Files 2011, accessed on the 31st of August 2015 at: <http://www.cso.ie/en/census/census2011boundaryfiles/>

Economic and Social Research Institute (2013) *Perinatal Statistics Report, 2012*. Dublin: Economic and Social Research Institute.

Appendix A: List of Respondent Organisations

- Alcohol Action Ireland
- Alcohol Forum
- ASH Ireland
- Association for Improvements in the Maternity Services Ireland (AIMSI)
- Association of Lactation Consultants In Ireland (ALCI)
- Asthma Society of Ireland
- Baby Friendly Health Initiative in Ireland
- Cavan General hospital
- Clinical Governance Group and Designated Midwifery Officers for the HSE Home Birth Service
- Senior Midwifery Group, Cork University Maternity Hospital
- Cuidiú - Irish Childbirth Trust
- DeafHear.ie
- Early Learning Initiative, National College of Ireland
- Faculty of Paediatrics, Royal College of Physicians of Ireland
- Faculty of Public Health Medicine of Ireland, Royal College of Physicians of Ireland
- Galway Midwifery Practice Development Unit, University Hospital Galway
- Galway Perinatal Mental Health Working Group
- Homebirth Ireland
- HSE Health & Wellbeing Child Public Health & National Steering Group for the Revised Child Health Programme
- HSE National Physical Activity Coordinator Group
- HSE National Project Manager - Obesity
- HSE West Sligo/Leitrim West Cavan Public Health Nursing Service
- Institute of Community Health Nursing
- Integrated Hospital Community Midwifery led Service . Wexford General Hospital
- International Baby Food Action Network, Ireland
- Irish Association of Directors of Nursing and Midwifery
- Irish Association of Speech and Language Therapists
- Irish Cancer Society
- Irish College of General Practitioners

- Irish Doula Directory
- Irish Institute of Mental Health Nursing
- Irish Medical Organisation
- Irish Nurses and Midwives Organisation - Midwives Section
- Irish Society of Chartered Physiotherapists
- Irish Society of Homeopaths
- La Leche League of Ireland
- Letterkenny Maternity Unit
- Maternity Unit Portiuncula Hospital, Ballinasloe Co. Galway
- Mayo General Hospital Maternity Service MDT
- Mental Health Ireland
- Mental Health Reform
- MindfulBirth Therapies
- National Breastfeeding Co-ordinator, Health Promotion & Improvement, Health & Wellbeing Division, HSE
- National Clinical Effectiveness Committee (NCEC)
- National Maternity Hospital, Holles Street, Dublin 2
- National Midwifery Education Group, sub group of the ADCNME group
- National Social Inclusion Office, Health Service Executive
- National Women's Council of Ireland (NWCI)
- NMPD HSE West Midwest
- Nursing and Midwifery Board of Ireland
- Office of the Area Manager, HSE Dublin North City Area & NMPDU Dublin North
- Office of the Nursing and Midwifery Services Director
- Our Lady of Lourdes Hospital Drogheda
- Pavee Point Traveller and Roma Centre
- Policy Department, Royal College of Physicians of Ireland
- Practice Nurse Midwives in General Practice
- Psychological Society of Ireland; Perinatal and Infant Mental Health Special Interest Group
- RCSI Hospital Group- The Rotunda, Our Lady of Lourdes and Cavan Hospitals
- Safefood

- School of Nursing and Midwifery, University College Cork
- Service User Representative Body, Sligo General Hospital
- Tallaght Hospital Action Group
- The Academy of Clinical Science and Laboratory Medicine
- The Baby Feeding Law Group Ireland (BFLGI)
- The Irish Hospice Foundation
- The Irish Institute of Pharmacy
- The Irish Nutrition and Dietetic Institute (I.N.D.I.)
- The Irish Society of Obstetric Anaesthesia
- The Rotunda Hospital Parnell Square, Dublin 1
- Tralee Women's Resource Centre
- Trinity College Dublin
- UCD Midwifery
- UK Birth Centres

Appendix B: List of individual respondents who consented to have their names included as contributors

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Agnes Tully Clarke	Aisling O'Brien	Amy O Brien
Aideen Barry	Aisling O'Toole	Ana Bermingham-Doran
Aileen Fox	Aja Teehan	Anastasia Ryan
Aileen Garrihy	Alanna Macey Hogan	Andrea Hanover
Ailish Murphy	Alannah Kate O'Toole	Andree Doyle
Aimee Finn	Alexis Forde	Angela Cahill
Aine Alam	Ali Gibbons	Angela Jenkins
Áine Bates	Ali Murphy	Anita Blair
Aine Moran	Alice Chau	Anita Byrne
Aine O'Callaghan	Alison Dingle	Anita Considine
Aine Roche	Alison McDonald	Anita Nic Amhlaoidh
Aishling O'Donoghue	Alison Merrick	Anja Byrne
Aisleen Gillespie	Alison Moore	Ann Dargan
Aisling	Alma Ryan	Ann Ellis
Aisling Dixon	Amanda Brady	Ann Louise Mulhall
Aisling Dollard	Amanda Whelan	Anna Boch
Aisling Finn	AMcCabe	anna coughlan

Anna McLaren	Aoife Devity	Brenda Reilly
Anna Visser	Aoife Hearne	Brenda Shields
Anna.	Aoife Lane	Brian Spollen
Anne Bergin	Aoife McGough	Bridget Cummins
Anne Clarke	Aoife McGreal	Bridin Carey
Anne Cutbill	Aoife Moroney	Bridin Coleman
Anne Flynn	Aoife obrien	Bronagh O' Hara
Anne Graham	Ashley	c, f
Anne Kehoe	Attracta Doran	Caitriona Rayner
Anne Marie Gillooley	Audrey	Caoimhe Ní Néill
Anne Marie Kelly	Audrey Clarke	Caoimhe Whelan
Anne Marie Mccarthy	Audrey Conalty	Carina Briggs
Anne Marie O'Connor	Barbara Western	Carla Johnston
Anne Matthews	Beatrice Hosgood	Carmel Bradshaw
Anne Phelan	Bernie Burke	Carmel Duffy
Ann-Marie Joyce	Bernie Condon	Carmel Dunne
Antonia Mahony	Bernie Wemyss	Carmel O'Dwyer
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Aoife Bedford	Bonnie Boyle	Carol Foley
Aoife Boyle	Boon Wan Wang	Carol Grimes
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Aoife Coz	Brenda Mannion	Caroline Byrne
Aoife curtin	Brenda O'Toole	Caroline Copeland

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Caroline o Neill	Celine Maher	Claire Grogan
Caroline O'Toole	Chanelle Porter	Claire Mac Loughlin
Caroline Roche	Charlene Duff	Claire McKenna
Caroline Rocliffe	Charlotte Dewar	Claire Murray
Carrie Dixon	Charlotte McElvaney	Claire Reilly
Catherine Brady	Cheryl Poole	Claire Smith
Catherine Clarke	Christiane Albrecht	Clare Reilly
Catherine Cocoman	Ciara Barrett	Clare Smart
Catherine Duffy	Ciara Considine	Claudia Vani
Catherine Griffin	Ciara Dolan	Clíodhna Hughes
Catherine Hogan	Ciara Goodwin	Clíona Rea
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Catherine Lonergan	Ciara Parthiban	Colette Donnelly
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Sharon Pearse	Sinead Morris	Susan Kelly
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