Maternity Services in Ireland.

Where are we?  How did we get here?  How do we move on?

Dr. Sam Coulter-Smith, Master, Rotunda Hospital

Over the last 2-3 years Maternity services in Ireland have consistently been in the headlines for all the wrong reasons, there have been numerous high profile cases reported in the news, multiple investigations with associated recommendations, high profile Coroner’s inquests, a variety of HIQA and independent reviews.

It has now reached a point where the confidence of the public has been severely shaken and the quality of the services provided to our mothers and babies is questioned in the media on an almost daily basis. Much of the reporting has been sensationalist and out of context. Such stories are understandably frightening for prospective mothers and families.

In my paper prepared for today’s address to the Oireachtas Health Committee I consulted with my consultant and midwifery colleagues at the Rotunda. I will start by giving some background and try to put the current issues into context. I will then attempt to indicate ways in which confidence might be restored and the safety and quality of services insured for the future.

Historical Background

Ireland has historically had an excellent maternity service and for many years our maternity services were the flagship of our health service. The Rotunda was the first Maternity hospital in the country and is arguably the oldest maternity hospital in the world, having opened its doors in 1745 the Hospital became so busy it was soon to small and not fit for purpose so Bartholomew Mosse moved it to a new site on the outskirts of the north side of the city. The new hospital occupying Parnell Square opened in 1757 and has been there ever since. The Coombe Women’s hospital and Holles Street National maternity hospital were founded some years later and these three stand alone maternity hospitals have set the standard for maternity care in the country for many years.

If one looks at Ireland’s maternity outcome measures of performance the overall figures are very good with perinatal (baby) mortality rates at extremely low levels, our maternal mortality outcomes are also very good. Both compare very favourably when bench marked with other developed countries. In fact when comparisons are made between services internationally our outcomes are excellent when you take into account the staffing levels and the poor quality of the infrastructure from which our staff deliver the service. Ireland is close to the bottom of the list when it comes supporting our maternity services.

Having a baby is a perfectly natural and physiological phenomenon, and thankfully in the vast majority of cases things go perfectly normally. About 20% – 30% of women regarded as low risk become higher risk due to issues arising in the antenatal period or in labour.
Normality is not universal. It cannot be assumed that every woman will have a normal uncomplicated pregnancy with a perfect baby at the end of the pregnancy. There is a normal pregnancy loss rate of between 4-8 per 1000 live births. Most babies are normally formed and deliver in an uncomplicated fashion but some have either physical or chromosomal anomalies, some of these are identified during pregnancy and others not until after delivery. Sometimes these anomalies are lethal or life limiting and others require medical management of the neonate. Pregnancy losses occur normally due to pre existing conditions in the unborn baby, extreme prematurity or complications occurring during pregnancy and delivery.

In relation to maternal morbidity and mortality, women with pre existing medical conditions become pregnant and other women become medically unwell during pregnancy, some women develop complications during the course of pregnancy, some of which can be predicted and others which present acutely requiring emergency interventions.

The revelations appearing at regular intervals in the news over recent months need to be taken in context, a hospital delivering 2000 babies can expect to have between 8 and 16 baby deaths per year, half of these will be due to fetal anomalies or extreme prematurity, between 2 and 4 deaths per year would be due to unforeseen difficulties, placental issues or umbilical cord accidents. Thankfully deaths of normally formed babies at or close to term are unusual but they can and do happen. Some of these losses are preventable but others are not and in some cases despite having a detailed post-mortem the cause remains unexplained.

When these tragic events happen, Yes the event needs to be reviewed and examined, in some cases by the Coroner and based on the clinical evidence and a post mortem examination a report and recommendations made but this should be part of a proper clinical governance system and not a trial by media when the circumstances of this tragic event are not fully understood.

In order to explain where maternity services are at present we need to examine how we have got to this point in time.

Increased demand for services

In Ireland over 70,000 babies deliver annually, this is a figure which has increased significantly over the last 10 years. Despite multiple Maternity Strategy reports commissioned by the Dept of Health and the HSE, there has been little or no progress in developing new and up to date facilities for the provision of services. Even though demand and numbers have started to even off and reduce in some areas we are still 25% busier then we were in 2006.

Staffing levels

Despite international best practice guidelines on staffing levels, most of our bigger maternity units are significantly understaffed with both midwife to patient ratios and consultant to patient ratios being well below acceptable levels. The head count ceilings applied to our hospitals and moratorium on recruitment in addition to salary reductions across the board and only made things more difficult. We should have 1 consultant for every 350 deliveries in a
tertiary referral unit. We currently have 1WTE consultant for every 800 deliveries. The Midwife to patient ratio is also insufficient in the Rotunda alone we should have another 60 midwives to bring staffing to an acceptable level.

Ireland has the highest European birth rate 2004-2013 yet we have the third lowest number of consultant obstetricians per 100,000 women among the 34 OECD countries.

In 2003 the Hanley report recommended an increase in consultant numbers. Specifically for obstetrics the report set targets 179 by 2009 and 191 by 2013. By end 2014 we had 133.

In 2006 the Institute of Obstetricians and gynaecologists recommended 24 hour on site cover in the bigger units. A figure of 1 consultant for every 350 deliveries was recommended. This would require the current number of consultants to be increased by 57%.

KPMG Report 2008- ‘’an expansion of consultant numbers is required’’

HIQA Galway 2013 ‘’There are a relatively low number of consultant obstetricians in Ireland’’

That is more than 10 years of reports saying the same thing-

I’m not sure how many more investigations, reports, recommendations are required or how many more adverse events will be required to get those who oversee and fund the health service to recognise the need to invest in the quality staff required to keep our mothers and babies safe.

Complexity

The increasing complex nature of the patients we deal with has become a feature of everyday practice, obesity affecting 30-40% of our patients brings with it increased risk and by extension increased cost, unusual and resistant infections are now much more frequent. Women with complex co-morbidity now conceive requiring multidisciplinary care across several services. Population diversity has brought challenges of new disease entities, greater social and communication issues. No additional funding has been put in place to deal with these issues.

Funding

These 3 factors increased demand, reduced staffing and increased complexity have coincided with a protracted recession which has affected government funding and has resulted in a significant fall in budget allocation for all our hospitals. As a Voluntary hospital 20-30% of our budget is generated from fee paying patients. Over the last 3-4 years the number of fee paying patients has fallen again due to the recession, many of these patients now attend the public clinics, this has left us with a funding shortfall because over all activity levels have not fallen significantly.
We know that maternal and perinatal mortality rates rise when government funding reduces yet between 2009-2012 the busiest time in the history of modern Irish obstetrics health spending was cut by 3.7%.

Lost opportunities to co locate.

There were opportunities to develop new and co located maternity units when there was more funding available during the boom years but these opportunities were missed.

As tertiary referral unit for the whole island we are constantly under pressure to take on care of our most complicated mothers, but None of the 3 major maternity hospitals have immediate access to Intensive care for adult patients, sick mothers are transferred by ambulance to adult hospitals away from their newborn babies, Access to appropriate imaging such as CT or MRI has to be organised off site. Access to joint services and multidisciplinary team care requires complex agreements between different hospitals on different sites and occasionally in different groups.

Retention and recruitment of staff

All of these factors combined have resulted in all hospitals having difficulty retaining and recruiting quality staff, The exodus of our excellent trainees to more attractive packages abroad continues resulting in an over reliance on locum and agency staff. This drives cost up and quality down and is no way to run a health service.

Guidelines

In recent years the HSE set up clinical programmes in most specialities which have assisted greatly with the provision of national clinical guidelines, this was a welcome development. However, unfortunately there was no provision of additional resources to allow some of these best practice guidelines to be put into action. Many hospitals do not have the infrastructure or the staff to implement such guidelines. Despite the availability of good solid information on where staffing levels should be, no effort has been made to bring levels of staffing up to recommended ratios.

Better incident reporting has assisted with improved knowledge of clinical incidents, but without the factors we have identified above being addressed it is difficult to see how we can improve the situation.

Variety of hospitals

Our Maternity services are delivered from 19 units around the country. Some are large voluntary stand alone tertiary referral teaching hospitals with no attachment to an acute adult hospital, some are big units in teaching hospitals governed by the HSE and others are smaller units in HSE hospitals. Some of the smaller units do not have a critical mass of patients and cannot provide the full range of maternity services, in addition their neonatal cover is provided by paediatricians with no subspecialist neonatal consultants on site.
Inequality of access to services

Patients in different parts of the country do not have equity of access to subspecialist services, for example only in the bigger teaching hospitals with recognised fetal medicine specialists are patients offered routine 20 week anatomy screening scans. In the tragic situation where a baby dies only in the bigger hospitals will the dedicated bereavement team be called in and a dedicated perinatal pathologist be available to do a post-mortem to get the best information as to what the cause of death may have been. Our sickest mothers are often transferred to the Dublin maternity hospitals, but none of us are collocated with acute adult hospitals, we do not have Intensive care beds onsite, we do not have access to the most modern imaging techniques. This inequity of access to services and the requirement to transfer our sickest patients often separating them from their babies needs to be addressed.

Governance Structures

HSE (state owned) Hospitals report directly to HSE. Maternity units in HSE hospitals therefore have no direct governance relationship with the HSE and the performance indicators set for those hospitals by the HSE do not and never did relate to maternity services or their outcomes.

This lack of direct oversight and a reporting relationship which was not designed to identify clinical risks has led to either failure to or delayed response to clinical issues. This lack of good governance procedures in some HSE hospitals has been pointed out in several recent reports.

It has been difficult over the last 7-8 years to get someone to listen and take on the issues we are highlighting today. Each of us, on multiple occasions have highlighted issues and concerns for the services we provide stressing the importance of staffing levels, infrastructure and resources. The same issues have been highlighted in officially commissioned reports yet little or nothing has been done to address our concerns. This speaks volumes and suggests that those overseeing the health service at the highest levels were more interested in budgets and headcount then safety of services. We need to get to a point quickly where clinical issues take centre stage.

Mastership System

Dublin’s three Maternity hospitals are run on a different governance model, each has a Master/CEO at the helm and a voluntary Board of governors to report to. The voluntary Board is responsible for the oversight of all the hospital activities and the Master reports to the Board on a monthly basis. The Dublin hospitals publish their results annually in a publicly available document called the annual clinical report. The results are assessed by an external assessor and benchmarked against one another. Some of the other units in HSE hospitals publish an annual clinical report but it is not universal practice.
The Voluntary hospitals receive an allocation from the HSE under a service level arrangement, the allocation is not based on activity and in fact as numbers of patients have increased the allocation has reduced. The Voluntary hospitals also meet with the HSE to review performance, however the performance indicators are set by the HSE and relate to finance staffing levels and clinical indicators which relate more to a general hospital then a maternity service. The HSE will of course say that in response to rising activity the moratorium on recruitment was lifted and headcount restrictions were reduced but of course with a reduced budget allocation and strict directives to stay within budget there is no opportunity to employ additional staff even if they were available.

**Hospital Groups**

The oversight and running of our health service is currently going through another transition. The country has been divided up into regions each one serviced by a Hospital group based around an academic partner. The groups have been very slow to evolve. The appointment of CEOs has also been slow and too many changes have already occurred. The group CEOs were supposed to have boards to report to but these have not been appointed.

The delay in driving this process carries the risk of leaving a vacuum at a governance level particularly for the non voluntary hospitals. This vacuum is creates a dangerous lack of oversight and needs to be addressed urgently.

Little or no thought has been given as to how the voluntary hospital fits into this model. The Minister has indicated that he sees the voluntary hospitals, particularly the maternity hospitals playing an important role in the new groups, yet it is unclear how this is going to work. There is a real fear that under the currently proposed model the voluntary sector which has contributed so much to the development and improvement of our services may be threatened by extinction. This in our view would be a very retrograde step for maternity services.

**Gynaecology**

Lack of foresight and planning led to failure to plan for more women of child bearing age having babies from 2006 on, again we did not avail of opportunities to expand when times were good. This has resulted in a demand led crisis in maternity hospitals where most of Dublin’s gynaecology also happens. Currently huge numbers of women are awaiting Gynae appointments for fertility issues and there is also the possibility of delayed diagnosis of Gynae cancers in some women.

**Litigation**

Ireland has a reputation for high levels of medico legal claims and Obstetrics is a high risk specialty. Twenty percent of the total claims arise from Obstetrics and midwifery practice but this accounts for up to 60% of the monetary value of claims. This amounts to about €60m annually, enough to run one of the Dublin Maternities for more than a year. The State claims agency deals with this and shares information with individual hospitals but there is no national learning from this hugely valuable information.
Models of care

The majority of pregnancies are low risk and for the most part no medical intervention is required. However, low risk women can become high risk and high risk women can also deliver normally. Pregnancy can be unpredictable and what was thought to be a low risk situation can very quickly become an emergency. All women regardless of their risk categorisation should be entitled to the best possible facilities and the best possible one to one midwifery care with access to medical intervention as required.

There has been much discussion around models of care and very vocal groups suggesting that midwifery led models are better. The delivery of Maternity services requires coordination of both midwifery and medical obstetric services, it is impossible to separate these two functions because low risk women can become high risk with little of no warning, therefore, in most developed countries care of women in pregnancy is shared between these two professional groups. The important thing is that all mothers have access to the best possible facilities in the most relaxed surroundings with good continuity of care looked after by midwives experienced in both normal and complex labour. Women who remain low risk can be delivered by those midwives and those who become more complicated can retain their continuity of care with that midwife but responsibility moves seamlessly to the medical team. There should be no need to move a patient in labour to a different location and continuity should be maintained.

If we genuinely want patient centred care then we need to get away from the idea that one professional group has ownership over pregnant mothers. In fact the terms midwifery led and medically led care should be abandoned because they put the professional at the centre and not the patient. All patients regardless of their risk category should be able to access the best midwifery and medical expertise as it is required delivered from comfortable surroundings. Care based on need is really what is required.

There is no doubt that ante natal care to low risk women should be delivered in a community setting, this would cut out long waits in hospital outpatient clinics, and allow hospital services to be devoted to higher risk patients. There needs to be significant investment in these community services to promote this model.

Fetal abnormality.

The area of fetal medicine has been the biggest growth area in obstetric services in recent years. With improved scanning technology and personnel trained in the area of fetal medicine and increased consumer demand for services. There are two principal issues around this service.

Firstly Equity of Access- fetal medicine services are delivered by a highly skilled and experienced multidisciplinary team. Not all patients have equal access to these services as they are mostly available in the bigger units.

Secondly -These services have evolved with time and problems are now identified earlier then ever before. The issues around supporting these women and their families now assumes
much greater importance. Some women will choose to travel abroad to terminate while others will choose to continue their pregnancies here. As obstetricians we need to be able to support women in their choice when facing this devastating situation. The current protection of life in pregnancy legislation was welcome and put some structure and guidance around what to do when a woman’s life is at risk. However that particular legislation does not assist us when faced with a woman carrying a baby with either a fatal abnormality or one where the anomaly is life limiting.

Having identified the issues we believe need to be tackled, I would like to make some suggestions to the Minister to assist in improving the quality of services and help restore confidence in our services. I hope these suggestions will help to inform the work and output of the new national strategy group.

1. Set up a clinical governance system in each of our maternity units to oversee clinical activity, with appropriate clinical audit and clinical risk reporting and incident review to allow units to benchmark against each other, this system should mirror what currently exists in the Dublin hospitals where a clinician leads the service and is accountable for its provision.

2. Each unit delivering maternity services should have a sufficient critical mass of activity to support the full range of services required to deliver quality care to the population it serves. We believe this is 4000-5000 births annually. This may require examining the models of care provided in some units or the provision of satellite clinics in some areas. These decisions can be made on a needs assessment of care.

3. Each unit should have facilities to provide care for the full range of complexity of care form the normal midwife model to the more complex medical model with seamless transition between the two again based on patients needs. The terms midwife led or consultant led should be dropped, all patients should have equal access to best qualified midwives and best quality facilities and transition seamlessly to medical care if indicated.

4. Low risk patients should be looked after by midwives based more in the community where possible, keeping hospital clinics for the more complex patients. The midwives delivering the community based care should rotate through the hospital at intervals to maintain their skills, keep up to date with guidelines and stay familiar with current practice.

5. A well organised and fully resourced national transport system to build on what currently exists to allow transport of mothers and babies to an appropriate setting when required.
6. Our tertiary referral maternity centres should be co-located with acute adult hospitals which can support the requirements of the high risk patient, with access to ITU and Radiology services, stand alone maternity units should be a thing of the past.

7. Our maternity units should be staffed to a level commensurate with accepted international standards, this was recommended in the KPMG report 2008 but has never been acted on despite being adopted as HSE policy. Failure to provide appropriate working arrangements for highly skilled and motivated staff will lead to further and worsening of the current manpower crisis.

8. The staff of the health service are its most valuable asset and need to be treated as such. Pay and conditions need to be restored to a level where as a country we can compete with services in other countries. We still have one of the lowest midwife and consultant ratios in the developed world.

9. In moving toward the hospital groups any governance system put in place should recognise the value that voluntary hospitals have given in the development of our service and foster the values and ethos of these institutions.

10. The valuable work led by the national lead in the production of national guidelines needs to be accompanied by resources to allow their implementation. This issue has not been addressed adequately.

11. The maternity services need to have access to the state claims agencies information relating to adverse incidents and claims. This is hugely valuable information, it would allow clinical issues and trends to be identifiable, benchmarked highlighted and appropriate interventions possible. This information would need to be monitored in an agreed way possibly through the national lead and clinical programmes. This data will be sensitive it will need to be anonymised and appropriate confidentiality measures put in place.

Between Dublin’s three maternity hospitals we cover almost half the deliveries in the country. We believe we have a unique perspective and valuable experience to offer. While we accept that each of our hospitals has from time to time been involved in cases and issues where outcomes could and should have been better we believe that through good governance and oversight we have responded to those issues and put systems in place to improve the quality of our outcomes and the service to our patients. We not only benchmark against each other but also internationally, we believe our systems are robust and should be replicated across the country.

We believe the governance structures in place over our maternity services across the country have not served us well, a combination of the current recession, failure to invest in hospital infrastructure in the past and failure to listen to clinicians and midwives has caused the current situation to evolve.
Our health service is the people who work within it. We need to support and value these people.

Failure to act or further delay in implementing the suggestions we have made will only serve to further damage public confidence and make it all the more difficult to retain and recruit quality staff in the future.