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Governance of maternity services: Effects on the management of perinatal deaths and bereavement services

Änne Helps[a,b,c,*], Sara Leitao[a,b], Laura O'Byrne[c], Richard Greene[b,c], Keelin O'Donoghue[a,c]

[a] Pregnancy Loss Research Group, The Irish Centre for Maternal and Child Health Research (INFANT), University College Cork, Cork University Maternity Hospital, 5th floor, Wilton, Cork, Ireland
[b] National Perinatal Epidemiology Centre (NPEC), University College Cork, Cork University Maternity Hospital, 5th floor, Wilton, Cork, Ireland
[c] Cork University Maternity Hospital, Wilton, Cork, Ireland

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ABSTRACT

Background: External inquiries are carried out following adverse maternal/perinatal events, to examine the care provided and make recommendations to improve it. Clinical governance ensures that organisations promote high-quality care and are accountable for the care they provide, thus contributing to its improvement.

Objective: This study examined how Irish perinatal bereavement services and the management of perinatal deaths (including events leading up to the deaths) were affected by developments in maternity services governance as described in ten Irish enquiry reports published over 14 years (2005–18).

Methods: Two clinicians collected data from the ten enquiry reports by using a specifically designed review tool. Thematic analysis was carried out, following the steps of familiarising, coding, identifying, grouping and revising themes.

Findings: Seven main themes were identified: workforce, leadership, management of risk, work environment, hospital oversight, national documents, data collection. Eight reports noted shortcomings in staffing levels, with a workforce that was under-resourced, and at times carried excessive workloads. The absence of 24/7 midwifery-shift leaders in maternity units resulted in problems with care at times not being escalated appropriately. The absence of a widely-owned, understood strategic plan for the management of the maternity services was mentioned in the reports from 2013.

Conclusions and implications for practice

The National Bereavement Care Standards were published in 2016 to address deficiencies identified in the enquiry reports and to standardise perinatal bereavement care across Irish maternity units. Though the first Irish Maternity Strategy (2016–26) was published in 2016, its implementation is incomplete. Inconsistencies remain in the definition and collection of national perinatal data, as well as concerns regarding the lack of local audit activities on pregnancy outcomes. Greater focus on hospital oversight, implementation of national documents and reliable data collection is required. To be effective and initiate positive changes in clinical services, documents such as incident reviews, national strategies and national reports including inquiries, need to include realistic recommendations with clear timelines and responsibilities for implementation.

Introduction

The aim of clinical governance is to ensure that organisations, and the individuals within them, promote and are accountable for the clinical care they provide, thereby continuously striving to improve the quality of care (Arulkumaran, 2010; Ferguson and Lim, 2001). The Irish Department of Health stated that clinical governance "defines the culture, the values, the processes and the procedures" of a hospital that are necessary to provide consistent excellent care (Department of Health (DOH) 2008). Clinical governance can be divided into various elements or "pillars" including but not limited to: leadership, adequate workplace, well-trained workforce, up-to-date guidelines, risk and incident management, information management, patient involvement (Arulkumaran, 2010; Department of Health (DOH), 2008; Flynn et al., 2015).

* Corresponding author: Cork University Maternity Hospital, 5th floor, Wilton, Cork, Ireland.
E-mail address: Aenne.helps@ucc.ie (Ä. Helps).

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Using these pillars, standards for clinical services are regularly evaluated and updated to create a just and considerate hospital culture for both patients and staff (Arulkumaran, 2010; Brennan and Flynn, 2013). Where there is ineffective clinical and non-clinical leadership and/or management this can be challenging (Arulkumaran, 2010). Therefore, the oversight of clinical activities and clinical workplaces needs to be specified in governance structures with defined ranks of accountability and responsibility (Brennan and Flynn, 2013).

Standards of maternity care are set out in Ireland by the Health Information and Quality Authority (HIQA) and the Department of Health, to ensure consistent, high-level maternity services nationally (Department of Health (DOH) 2016; [1](Information and Authority, 2016). Then, outcomes can be monitored in line with these standards, and changes in services made to address and reduce outcome deviations from the expected standard e.g. the rate of intra-partum stillbirths (Arulkumaran, 2010; Royal College of Obstetricians and Gynaecologists, 2016).

In Ireland, maternity outcomes from all 19 maternity units are monitored using the annual Irish Maternity Indicator System (IMIS) National Report, published since 2014, and the monthly published Maternity Patient Safety Statements (MPSS) from individual units since 2015 (NWHIP, 2019). National perinatal mortality data has been collected and published by the National Perinatal Epidemiology Centre (NPEC) for its annual audit since 2008 (O'Farrell et al., 2019). Perinatal mortality is the combination of stillbirths and neonatal deaths (O'Farrell et al., 2019). In Ireland, these include infants from 24 weeks gestation and/or weighing more than 500 g (O'Farrell et al., 2019). Pregnancy losses at lower gestations are considered first and second trimester miscarriages.

HIQA was established in 2007 under the Health Act 2007. The National Standards for Safer Better Healthcare were published by HIQA in 2012 to "promote responsibility and accountability for the quality and safety of services provided", followed by the National Standards for Safer Better Maternity Services in 2016 [2](Information and Authority, 2016).

The first Irish National Maternity Strategy was published by the Department of Health in the same year to ensure that maternity and neonatal care "is safe, standardised, of high-quality and offers a better experience and more choice" to women and their families (Department of Health (DOH) 2016). In Ireland, maternity care has been provided free under the Maternity and Infant Care Scheme since 1954. In maternity units, this care is provided under the remit of the Health Service Executive (HSE). Over 99% of births in Ireland occur in a maternity hospital, with 4% of these being midwifery-led while the remainder are obstetric (consultant)-led (Department of Health (DOH) 2016). However, the primary care is provided by midwives and unless some intervention (e.g., operative vaginal delivery or caesarean section) becomes necessary, births are not routinely attended by medical staff. Since 2017, the National Women and Infants Health Programme (NWHIP) heads the management, organisation and delivery of maternity and neonatal services in Ireland, as well as oversees the implementation of the Maternity Strategy.

This paper outlines how Irish perinatal bereavement services and the management of perinatal deaths (including events leading up to the deaths) were affected by developments in maternity services governance as described in ten enquiry reports published over 14 years (2005–18).

This study provides an overview of elements of maternity services which either were affected by or in turn affected governance structures. Additionally, it suggests recommendations for changes in local and national maternity services governance to enhance perinatal bereavement services.

[1] This reference should be: (Health Information and Quality Authority, 2016) as in the original text, NOT (Information and Authority, 2016)

[2] Please see previous footnote regarding this reference. It should read (Health Information and Quality Authority, 2016).

Methods

From all national inquiries into the maternity services in Ireland over the last 15 years, ten relevant health-service-commissioned enquiry reports relating to perinatal deaths and pregnancy loss services, were identified (Flory, 2015; Health Service Executive, 2008, 2011, 2013, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014; Madden, 2005). The reports covered issues in relation to paediatric post-mortem examinations; the management of pregnancy loss; maternal and perinatal deaths in different Irish maternity units (including events leading up to the deaths); miscarriage misdiagnoses; maternity services governance; maternity related complaints received by the HSE.

Ethical approval was not required as all the reports are publicly-available documents. The enquiry reports were assessed by two clinicians, separately, between October and December 2018, using a specifically-designed review tool to compare and examine the content and recommendations made in each report. The review tool was based on the Irish Health Service Executive (HSE) Systems Analysis Review Report Checklist and consisted of 21 items divided into 6 separate sections covering the terms of reference, review methodology, key findings, contributory factors and recommendations (Helps et al., 2020b). In a published review the characteristics of the ten reports are discussed in detail (Helps et al., 2020b). A further publication outlines the impact of perinatal bereavement care on families as described in the reports (Helps et al., 2020c).

Following on from data collection using the review tool, qualitative content analysis of the reports was used to identify the main domains. The domain of maternity services governance informed the following thematic analysis to identify the relevant themes. Thematic analysis with a semantic approach was carried out following the steps of familiarising, coding, identifying, grouping and revising themes, followed by writing this article (Braun and Clarke, 2006). Various issues relating to maternity services governance were thus initially identified and coded. These codes were further explored and discussed by three authors with the assistance of a thematic mind-map until the seven governance-related themes were agreed on. By re-analysing the reports for clarification (focussing on the key findings and recommendations) these seven themes were finalised.

Two peer debriefing sessions, with a qualitative researcher and with an expert in perinatal medicine/pregnancy loss, were carried out to consider the analysis process and the themes. Of note, the authors collectively have considerable years of experience of working in the Irish maternity services, including in positions of authority.

Results

Seven main themes regarding perinatal bereavement services and management of perinatal deaths informed by maternity services governance were identified from the ten Irish enquiry reports. Table 1 shows the themes relating to elements which were affected by or in turn affected clinical governance structures. The number of reports in which each theme was mentioned is also highlighted. In the sections below we will explore each theme in detail.

Elements affected by governance structures

The following four elements are affected by maternity services governance structures. Issues with these elements have a direct impact on the management of perinatal deaths and bereavement services.

Workforce

Staffing levels, staff training and professional competence were identified as parts of the theme workforce. Eight reports noted shortcomings in staffing levels, with a workforce that was under-resourced, and at

Table 1
– Elements affected by or in turn affected governance structures in the management of perinatal deaths and bereavement services.

Elements affected by governance structures	Reports (*N* = 10)	Elements that affected governance structures	Reports (*N* = 10)
Workforce	10	Hospital oversight and networks	8
Leadership "hospital culture"	10	National documents	8
Management of risk	9	Data collection	9
Work environment	6		

Table 2
– Quotes from the Inquiry reports.

Number	Element	Quote
1	Workforce	"There was a chronic shortage of staff both at midwifery and consultant level with a lack of consistent midwifery management presence to supervise the labour ward during the period under review. This was compounded by the national moratorium in the public sector implemented by the Department of Finance in 2009." (Health Service Executive, 2018a)
2a	Leadership "hospital culture"	"Poor standards of multidisciplinary communication were highlighted by a number of people who met with the Authority. Yet, these concerns were reported as far back as 2007 and had not been addressed. Multidisciplinary communication had also been highlighted as problematic in the safety culture assessment carried out as part of this investigation." (HIQA, 2015)
2b		"There is an ongoing and critical discussion about maternity services playing out through the media. This contributes to a culture of fear of getting it wrong amongst some healthcare professionals who can become more cautious or even defensive in the course of their work. If this impacts upon the decisions about the care of patients then high quality appropriate care can be compromised." (Flory, 2015)
3	Management of risk	"No common process for development of recommendations was evident across the adverse incident reports. There was an absence of timeframes, identification of responsibility and accountability and evidence of completion for implementation of recommendations." (Holohan, 2014)
4a	Work environment	"The Investigation Team found that staff are continuously challenged by the current infrastructure to deliver a person-centred service, particularly in the context of maintaining patient privacy and dignity." (HIQA, 2015)
4b		"There were numerous cases where the assessment of an abnormal CTG, escalation of this and failure to act appropriately was of particular concern. There was a failure in carrying out foetal blood sampling with a lack of training in its use."(Health Service Executive, 2018a)
5	Hospital networks	"Smaller hospitals… cannot operate in isolation as standalone entities either clinically or financially. They simply cannot sustain the breadth and depth of clinical services that the populations they serve require without formal links and networks with bigger, more specialist units." (Flory, 2015)
6	National documents	"The absence of clear guidelines regarding required observations and reactions and the lack of a structured format for recording vital signs contributed to the delayed medical intervention." (Health Service Executive, 2008)
7	Data collection	"At the time of the investigation, there was also no agreed national dataset of quality and safety measures for maternity services in Ireland and no consistent approach to reporting clinical outcomes."(HIQA, 2013)

times carried excessive workloads (Flory, 2015; Health Service Executive, 2008, 2011, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014). Relevant specialists (e.g. perinatal bereavement, perinatal mental health) were not always available resulting in varying supports being available to bereaved parents (Helps et al., 2020c). Understaffing was present at midwifery, non-consultant hospital doctor (NCHD) and consultant level as well as in management positions and administrative support (Table 2, Number 1) (Flory, 2015; Health Service Executive, 2008, 2011, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014). This resulted in extensive use of agency and locum staff.

As previously advised in a national Consultant Workforce Planning report from 2015 (National Clinical Programme Obstetrics and Gynaecology, 2015), the enquiry report from 2018 recommended that both midwifery and consultant obstetrician numbers needed to be increased to internationally accepted levels, allowing for a one-to-one ratio of midwife to woman in labour in all units (Health Service Executive, 2018a). Furthermore, specialist services such as perinatal mental health and bereavement care needed to be expanded, to allow access for all women who require them (Health Service Executive, 2017). Six reports included recommendations relating to the recruiting, reviewing and retaining of a clinical and managerial workforce that is fit for purpose (Health Service Executive, 2008, 2011, 2017, 2018a; HIQA, 2015; Madden, 2005).

Four successive reports raised concerns regarding the lack of formal and mandatory training programmes for: induction of new staff, foetal monitoring and multi-disciplinary emergency training (Health Service Executive, 2011, 2013, 2018a; HIQA, 2015). Hospitals under investigation were not consistently able to produce records of training for all staff. Access to training, both in relation to providing protected time and facilitating attendance at off-site courses, was reported as limited.

The maintenance and updating of clinical skills in-line with international best practice was reported as haphazard. Circumstances of unprofessional behaviour and lack of competence by staff were described, including non-disclosure of harm and lack of appreciation of changing clinical circumstances (Health Service Executive, 2008, 2013, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014; Madden, 2005).

Leadership "hospital culture"

Occasional accounts of an absence of a compassionate culture at individual or organisational level were recorded with "a system and culture that failed to take into account the views and feelings of parents" (Madden, 2005). Different staff groups were reported as having varying perceptions of the safety culture with some staff fearing challenging clinical situations, hence becoming either overcautious or too reactive to clinical incidents (Table 2, Number 2a) (Flory, 2015; HIQA, 2015).

It was stated that in some units there were gaps in key management positions; elsewhere management structures did not function well due to hospital group governance changes with senior staff not feeling in charge of their own clinical environment (Flory, 2015; Health Service Executive, 2018a; HIQA, 2015; Holohan, 2014). Some senior staff in key leadership positions had unrealistic clinical and administrative workloads, lacking the time for informal mentoring of colleagues where personal or organisational concerns could have been raised.

Without a director of midwifery in every maternity unit up to 2019, there was inconsistent senior midwifery input at some clinical governance meetings ((Information and Authority, 2020)[4]; Health Service Executive, 2018a; HIQA, 2015). The absence of a 24/7 midwifery-shift leader in maternity units resulted in problems with care at times not being escalated appropriately (Flory, 2015; Health Service Executive, 2018a; HIQA, 2015). One report highlighted that suitable midwifery-led care was not available, despite management having applied to develop this service (Health Service Executive, 2018a).

In some units the midwife-doctor relationship was described as very traditional, with poor multidisciplinary team-working and sub-optimal communications between professionals and specialities (Table 2, Number 2b). Uncertainty regarding patient-care responsibilities without clear communication and handover, as well as lack of senior clinical staff involvement, led to suboptimal care being provided at times. Eight reports advocated for improving the transfer of patient information between staff and four mentioned the need for increased consultant input/supervision into patient care (Health Service Executive, 2008, 2011, 2013, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014).

Management of risk

The management of risk includes risk recognition and incident investigation. Six reports, between 2008 and 2018, noted that lack of regular monitoring and inadequate risk assessments meant that at-risk or deteriorating maternity patients (both mothers and babies in-utero) were, at times, not identified early (Health Service Executive, 2008, 2013, 2018a; HIQA, 2013, 2015; Holohan, 2014). The need for an early warning score was mentioned in the reports in 2008, 2013 and 2015; the Irish Maternity Early Warning System (IMEWS) was introduced nationally in April 2013 (Table 3) (Health Service Executive, 2008, 2013; HIQA, 2013, 2015). Furthermore, concerns regarding delays and lack of clarity in care escalation, were raised. In some maternity units risk escalation policies were not well developed at both clinical or managerial level, with poor tracking and/or poor monitoring systems of identified risks (Health Service Executive, 2013).

Incidents (e.g., an unexpected perinatal death) were not consistently and/or comprehensively investigated. Incident investigations (reviews) that were carried out, were reported to be of varying quality and lacked timeframes and accountability for implementation of recommendations, as well as containing limited feedback to staff (Table 2, Number 3). There were significant delays in incident reviews and a lack of involvement of clinical staff and/or contact with the bereaved families during the review process (Health Service Executive, 2018a; HIQA, 2015; Holohan, 2014). Short-comings with open disclosure to families were highlighted, both immediately after an incident and regarding incident reviews taking place.

Work environment

Five reports published between 2011 and 2018 mentioned that some hospital buildings and equipment (e.g. foetal heart rate monitoring devices, ultrasound machines) were not fit for purpose (Table 2, Number 4a) (Flory, 2015; Health Service Executive, 2011, 2018a; HIQA, 2015; Holohan, 2014). Inadequate facilities with lack of privacy were said to add to bereaved parents' distress (HIQA, 2015; Madden, 2005). Furthermore, absence of essential services, lack of space and the layout of some maternity units with significant distances between departments (i.e. the labour ward, operating theatres and the neonatal unit) posed additional risks (Health Service Executive, 2018a; HIQA, 2015; Holohan, 2014).

Sub-optimal introduction of new services (e.g. foetal blood sampling during labour, neonatal therapeutic hypothermia) was said to have resulted in additional adverse outcomes (Table 2, Number 4b) (Health Service Executive, 2017, 2018a; HIQA, 2015). Some necessary practices were unintentionally disrespectful, for example the type of transfer of deceased infants to another hospital for post-mortem examination in one unit (Holohan, 2014). The lack of appropriately trained staff to provide comprehensive antenatal ultrasound services was criticised in reports from 2011, 2015 and again from 2018 (Health Service Executive, 2011, 2018a; HIQA, 2015).

Elements affecting governance structures

Below three elements raised in the reports, which affect maternity services governance, are described. Issues with these elements have an indirect impact on the management of perinatal deaths and bereavement services due to the way they are closely linked to hospital practices, and therefore the way in which services are delivered.

Hospital oversight and networks

Five reports raised concerns regarding a lack of national oversight of the maternity services, by both the Department of Health and the HSE, regarding ongoing local and/or national identified clinical risks e.g. access to appropriate and the right level of care 24 h per day for all pregnant women (Health Service Executive, 2018a; HIQA, 2013, 2015; Holohan, 2014; Madden, 2005). During the financial recession and until 2014 the main focus by senior HSE managers was on controlling health care expenditure (HIQA, 2015).

The absence of a widely owned and understood strategic plan to guarantee high-quality of maternity care was mentioned in the reports published from 2013 (Table 3). The National Maternity Strategy was published in 2016, however as the report from 2018 stated "the importance of the document is not what it says but whether it is implemented" (Health Service Executive, 2018a).

Clinical maternity networks (groups) have been recommended by the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland since 2006 to integrate smaller and larger units (The Institute of Obstetricians and Gynaecologists, 2006). While smaller hospitals are vital for their communities (Vaughan and Edwards, 2020), the smaller units require efficient intergroup co-operation with the tertiary centres for specialist services (Table 2, Number 5) (Higgins and Board, 2013). In 2014 Irish hospital groups were recommended and formed for governance, training and clinical services including risk categorisation and sharing of clinical expertise (Higgins and Board, 2013). These groups were different to the recommended networks in 2006 and the six health regions currently proposed for the implementation of Sláintecare, which is a ten-year programme to renovate the Irish health and social care services with a focus on delivering "the right care, in the right place, at the right time" (Department of Health, 2020; Higgins and Board, 2013; The Institute of Obstetricians and Gynaecologists, 2006). Reports from 2015 and 2017 explained that hospital groups were going through ongoing "set up and development" (Flory, 2015; Health Service Executive, 2017).

Multiple changes in governance arrangements during the formation of hospital groups was said to have led to confusion regarding management roles and responsibilities. Furthermore, due to "cultural, behavioural, operational or financial barriers" not all units were consistently and/or effectively integrated into maternity clinical networks (Flory, 2015). Some evolving group committee structures were reported

[4] This reference should read (Health Information and Quality Authority, 2020)

Table 3
– Name/year of document and year (report) in which issues related to it were raised.

Name of national guideline	Year published	Year [report] in which issues related to guideline were raised
The Irish Maternity Early Warning System (IMEWS) RCPI, Dept of Health	2013 (updated 2014, 2019)	2008 (Health Service Executive, 2008) Need for physiological observation, track and trigger type programme 2013 (Health Service Executive, 2013) Need to implement IMEWS 2013 (HIQA, 2013) Need for mandatory induction and refresher training 2015 (HIQA, 2015) Use of IMEWS for all maternity patients regardless of location in the hospital
Open Disclosure Policy (and Guideline) HSE	2013	2014 (Holohan, 2014) Need to implement policy 2015 (HIQA, 2015) Confirm policy is in use 2018 (Health Service Executive, 2018a) Monitor compliance with policy
Communication (Clinical Handover) in Maternity Services, including ISBAR (Information, Situation, Background, Assessment, Recommendation) tool Dept of Health	2014	2013 (Health Service Executive, 2013) Adoption of appropriate communication tools such as ISBAR 2013 (HIQA, 2013) Need for national guideline for effective communication 2014 (Holohan, 2014) Need for standardised and structured communication 2018 (Health Service Executive, 2018a) Need to introduce tools such as ISBAR to aid communication
Safety Incident Management Policy, replaced by Incident Management Framework in 2018 HSE	2014	2011 (Health Service Executive, 2011) Enhance capacity for hospitals to conduct investigations of incidents 2015 (HIQA, 2015) Local practices were contrary to the policy 2017 (Health Service Executive, 2017) Each Hospital should have in place a formal system of review 2018 (Health Service Executive, 2018a) Ensure incident investigations comply with policy
Name of standards/strategy	**Year published**	**Year (report) in which issues related to standards/strategy were raised**
National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death HSE	2016	2008 (Health Service Executive, 2008) Need for bereavement room, liaison person, staff training 2011 (Health Service Executive, 2011) Need for bereavement support 2013 (Health Service Executive, 2013) Need for availability of bereavement counselling nationally 2015 (HIQA, 2015) Need for bereavement care 2017 (Health Service Executive, 2017) Need for bereavement support and counselling 2018 (Health Service Executive, 2018a)
National Maternity Strategy – Creating a Better Future Together 2016–2026 Dept of Health	2016	2013 (HIQA, 2013) Need for a Strategy to optimise maternity services 2014 (Holohan, 2014) Recommendations from the report should be incorporated into the Strategy 2015 (HIQA, 2015) Urgent need for a Strategy to implement standard, consistent maternity care 2015 (Flory, 2015) Absence of a clear Strategy 2017 (Health Service Executive, 2017) Need to develop implementation plan for the recently published Strategy 2018 (Health Service Executive, 2018a) Need for national support to implement the changes proposed in the Strategy

to be overlapping and unnecessarily complicated, and some group meetings poorly attended by staff from the various units (Flory, 2015; Health Service Executive, 2018a; HIQA, 2015).

While it was noted that some audit, incident and risk management processes could be consolidated within the hospital group to share information, the importance of local learning points being disseminated was highlighted (Flory, 2015; Health Service Executive, 2018a).

National documents related to maternity services

Table 3 describes the type of national documents discussed in the reports as not available, poorly implemented or not in use in maternity units, and in which year these were published. National guidelines provide clear information on managing clinical conditions. Standards and strategies define the clinical care required for consistent safe services. Both types of documents aim to standardise and ensure good quality of clinical care. From 2010 national clinical guidelines for maternity services in Ireland were published by the HSE's national clinical programme, and this role has been taken over by NWIHP since 2017.

Eight reports mentioned the absence or poor implementation of clear clinical guidelines or guidance documents e.g. open disclosure policy and guideline (Table 2, Number 6) (Health Service Executive, 2008, 2011, 2013, 2018a; HIQA, 2013, 2015; Holohan, 2014; Madden, 2005). There were accounts of national and/or local guidelines not being used or not being adhered to in maternity units (Health Service Executive, 2018a; HIQA, 2013, 2015). It was stated that deviation from an agreed guideline can arise from staff unawareness, poor

communication of new guidelines or a new (not previously encountered) clinical situation (Health Service Executive, 2011).

Data collection

Duplication and inconsistencies were reported in the collection of national perinatal data involving four separate state agencies (Holohan, 2014). There were data inconsistencies between the 19 units relating to the quality of maternity services. An enquiry in 2013 found that only 11 out of the 19 units produced an annual clinical report (HIQA, 2013). The lack of an agreed national dataset as well as clinical outcomes was highlighted at the time (Table 2, Quote 7) (HIQA, 2013). In 2015 publically-available monthly Maternity Patient Safety Statements (MPSS) from all units were recommended and published by the HSE, in addition to the annual IMIS (Irish Maternity Indicator System) reports, which commenced in 2014.

Further, in 2017 it was recommended that "an annual audit of Irish maternity services" should be implemented (Health Service Executive, 2017). Reports from 2011, 2013, 2015 and 2018 advocated for an audit of compliance with national policies/guidelines e.g. the Open disclosure policy (Health Service Executive, 2011, 2018a; HIQA, 2013, 2015). In total, nine out of the ten reports made recommendations on improving comprehensive data collection (Flory, 2015; Health Service Executive, 2011, 2013, 2017, 2018a; HIQA, 2013, 2015; Holohan, 2014; Madden, 2005).

Concerns were raised in 2013, 2015 and 2018 about the lack of local audits on activities such as work-loads, adverse incidents and clinical outcomes (Health Service Executive, 2013, 2018a; HIQA, 2015). Ineffective information technology structures and a shortage of dedicated staff members to oversee audit activities were stated as contributory factors.

Discussion

We examined how Irish perinatal bereavement services and the management of perinatal deaths (including events leading up to the deaths) were affected by developments in maternity services governance as described in ten enquiry reports around seven themes (workforce, leadership, management of risk, work environment, hospital oversight, national documents, data collection). The themes of workforce, leadership, management of risk and work environment related to elements that were directly affected by clinical governance structures. On the other hand, issues with hospital oversight, national documents and data collection had an indirect impact on the management of perinatal deaths and bereavement services.

To address deficiencies identified in the enquiry reports related to perinatal bereavement services, the HSE National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death were published in 2016 (Health Services Executive, 2016). The aim of the Standards is to improve and standardise perinatal bereavement care across the 19 Irish maternity units (Health Services Executive, 2016). In the same year the first Irish Maternity Strategy was published to cover the period 2016–26 (Department of Health (DOH) 2016). NWIHP (National Women and Infants Health Programme) oversee the implementation of this Strategy.

HIQA (Health Information and Quality Authority) carried out inspections in all Irish maternity units between August 2018 and September 2019 to assess compliance with the National Standards for Safer Better Maternity Services (2016) and implementation of the Maternity Strategy (Department of Health (DOH) 2016; Information and Authority, 2016) [3], (Information and Authority, 2020)[5]). Findings in the current study highlight that the enquiry reports reflected similar concerns to those raised by HIQA who noted ongoing national shortfalls in: the formation of maternity networks, the formalisation of care pathways, the infrastructure of units, midwifery and medical staffing levels, uptake and recording of attendance at multidisciplinary training and measures to share learning (both good practice and when things go wrong) (Information and Authority, 2020)[6]. Furthermore, HIQA raised concerns regarding the level of progress of the implementation of the Maternity Strategy, which affects the provision of high-quality care in the maternity services and consequently perinatal bereavement service (Information and Authority, 2020)[7].

Four of the 19 Irish maternity hospitals currently are stand-alone units. However, the plan is to move these maternity units to be co-located with acute adult hospitals by 2040 (Health Information and Quality Authority, 2020). In agreement with the enquiry reports, NWHIP acknowledged in 2018 that "the majority of the 19 maternity hospitals/units require investment to meet current hospital accommodation standards" (National Women and Infants Health Programme, 2019). During their 2018/9 inspections HIQA found that none of the six Irish maternity hospital groups had completed the set-up of a single governance framework across their network, despite it being recommended since 2006 and pertinent concerns raised repeatedly in the enquiry reports from 2015 ((Information and Authority, 2020)[8]; The Institute of Obstetricians and Gynaecologists, 2006).

Even though it was highlighted in 80% of the reports, there is still an ongoing lack of continuous national workforce planning for the Irish maternity services, with ongoing reliance on agency staff and existing staff to work overtime to cover essential services (Information and Authority, 2020)[9]). However, since 2019 there is at least one Bereavement Clinical Midwife Specialist (CMS) employed in each maternity unit and perinatal mental health teams are in post in four of the six hospital groups (National Women and Infants Health Programme, 2019). Of note, the current COVID-19 pandemic has led to challenges with recruitment for the whole-time equivalent (WTE) specialist posts and some CMSs in post have been redeployed to other clinical areas.

While training for obstetric emergencies and foetal heart rate monitoring was being offered in all units in 2018/9, the attendance at these was suboptimal despite this being raised as a concern in the enquiry reports (Information and Authority, 2020)[10]. Units that are persistently under-staffed will not be able to facilitate staff to attend important training sessions, which in turn can affect staff morale (Smith et al., 2009).

Clinical staff members, as well as management and leadership behaviour contribute to the hospital culture through their attitudes, actions or inactions. Cohesive team behaviour and unified values have a positive impact on hospital culture, and if combined with supportive leadership, result in employees feeling valued and satisfied (Y., 2011). Unfortunately, a fragmented hospital or organisational culture can have detrimental effects on patient care as highlighted in the 2018 Inquiry report: "If people, systems or hospitals work in isolation, they stay rooted in the past. Practice becomes embedded and fails to progress"(Health Service Executive, 2018a).

In Ireland, as internationally, there is a shift in health care provision including maternity services from paternalism to greater emphasis on patient autonomy and open disclosure (Shakibazadeh et al., 2018). While this is a welcome change, negative publicity of events described in the ten enquiry reports created a loss of trust by the public in the Irish maternity services, sometimes resulting in a division between staff and patients instead of the desired partnership (McNamara et al., 2018; Meaney et al., 2016).

[3] Please see previous notes regarding this reference. It should read (Health Information and Quality Authority, 2016)

[5] Please see previous note regarding this reference. It should read (Health Information and Quality Authority, 2020).

[6] As per previous note on this reference.

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[9] As per previous note on this reference

[10] As per previous note on this reference

As a result of the enquiry reports from 2013 to 2014, the national guidelines on communication, including ISBAR, and IMEWS were published (Table 3). Using communication tools such as ISBAR (Identify, Situation, Background, Assessment, Recommendation) has been shown to improve the transfer of patient information between staff, thereby reducing the risk of not recognising the deteriorating patient because of missed vital clinical information (Marshall et al., 2009). Equally, having a structured method of recording vitals signs e.g. IMEWS can help to identify the deteriorating maternity patient early to prevent delays in required interventions e.g. expediting the delivery of the baby (Maguire et al., 2015).

If an adverse outcome, like an unexpected perinatal death, does occur it should be comprehensively investigated to identify any modifiable contributory factors (Liberati et al., 2019). Issues were raised in the reports from 2015 and 2018 regarding suboptimal local adherence to national incident policies. In 2018, the HSE Incident Management Framework replaced the previous national policy to provide guidance in the management of incidents while "supporting the needs of service users, families and staff in the aftermath of an incident" and facilitate learning from it (Health Service Executive, 2018b). Despite this Framework, in 2019, there was no consensus across the Irish maternity units regarding the timeframe of incident reviews or how the findings were shared with the affected families and staff (Helps et al., 2020 (under review).

Ninety percent of the reports advocated for robust local and/or a national perinatal data collection, including the need to benchmark maternity outcomes. National Irish perinatal data is collected by both NPEC (National Perinatal Epidemiology Centre) and the Healthcare Pricing Office (HPO) of the HSE (Healthcare Pricing Office, & Health Service Executive 2020; O'Farrell et al., 2019). Irish maternity outcomes are collated by both IMIS (national annual data) and MPSS (monthly unit-specific data) (NWHIP, 2019). While all four reports allow for local, national and international benchmarking of Irish perinatal data, there is some overlap and duplication between reports (Healthcare Pricing Office, & Health Service Executive 2020; NWHIP, 2019; O'Farrell et al., 2019). Furthermore, only NPEC makes recommendations based on their findings in their audit; HPO, IMIS and MPSS present data without recommendations (Healthcare Pricing Office, & Health Service Executive 2020; NWHIP, 2019; O'Farrell et al., 2019).

Over 250 recommendations were made in the ten enquiry reports, these are discussed in further detail in a previously published review (Helps et al., 2020b). Three of the enquiry reports highlight the incomplete implementation of previous enquiry recommendations (Health Service Executive, 2018a; HIQA, 2013, 2015). This concern was shared by the Irish public (Meaney et al., 2016).

Limitations

The foci and content of the ten enquiry reports differed considerably, however the reports all related to Irish maternity services covering different aspects of the management of perinatal deaths and bereavement services. In some reports the issues with the management of perinatal deaths were directly linked to maternity service governance, in others this link was not clearly stated. However, from the reports it was evident that governance of maternity services has a top-down effect on bereavement care.

Conclusion

Effective clinical governance is important to unite the managerial, organisational and clinical administration through clear structures and systems, thereby creating a just organisational culture and improving the quality of care (Arulkumaran, 2010; Brennan and Flynn, 2013). This study highlights that issues related to lack of leadership, workforce staffing levels, adequate infrastructures and effective risk management are still affecting the national maternity services. Furthermore, a greater focus on hospital oversight, implementation of national documents (e.g. guidelines, standards) and adequate data collection is required. The issues with all these elements of clinical governance must be brought together and addressed, to improve the quality of the investigation and management of perinatal deaths and the delivery of bereavement services.

To be effective and initiate positive changes in clinical services, documents such as incident reviews, national reports including inquiries, national standards and strategies need to include realistic recommendations. Furthermore, action plans have to be made and resourced for the implementation of these recommendations with clear timelines and responsibilities (Wirtz et al., 2011). Locally, if new safety ideas or recommendations do not filter down to the frontline clinical staff, few or no visible improvements will be achieved for women and their families attending maternity units.

Recommendations

Effective clinical governance is important to achieve clear structures and systems, with organisational and clinical administration creating a caring culture, thus it should be the priority for all maternity care

Outcomes of clinical care, including maternity care, should be monitored and improved according to agreed national standards. There is a need to bench-mark maternity outcomes nationally and internationally.

Ways to strengthen pathways for local learning, sharing lessons within maternity networks, at national, and potentially global level, should be developed.

National workforce planning in the maternity services, including progression plans, must be prioritised to reduce reliance on agency staff and overtime.

Author contributions

Änne Helps: Conceptualization, Methodology, Investigation, Formal analysis, Writing - Original Draft, Visualization

Sara Leitao: Conceptualization, Methodology, Formal analysis, Validation, Writing - Review & Editing, Visualization, Supervision

Laura O'Byrne: Investigation, Writing - Review & Editing

Richard Greene: Methodology, Writing - Review & Editing

Keelin O'Donoghue: Conceptualization, Methodology, Validation, Writing - Review & Editing, Visualization, Supervision

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