



**Trinity College Dublin**  
Coláiste na Tríonóide, Baile Átha Cliath  
The University of Dublin

# Establishing Postnatal Community Hubs in Ireland

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*A good practice guide based on lessons learned*



## Guide Development Group

- Dr Susan Hannon, Post-doctoral Researcher, School of Nursing and Midwifery, Trinity College Dublin.
- Dr Louise Gallagher, Associate Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin.
- Dr Vivienne Brady, Associate Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin.
- Dr Déirdre Daly, Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin.

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### **The Trinity Centre for Maternity Care Research (TCMCR) Research Group**

Dr Susan Hannon, Post-doctoral Researcher  
Dr Louise Gallagher, Associate Professor of Midwifery  
Dr Vivienne Brady, Associate Professor of Midwifery  
Dr Déirdre Daly, Professor of Midwifery

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## Foreword

I am pleased to present this Good Practice Guide and on behalf of the National Women and Infants Health Programme (NWIHP), would like to extend my sincere thanks to Dr Déirdre Daly and Dr Susan Hannon for their support and expertise as academic partners in this work.

As we continue to introduce and develop new services, it is important that we continuously reflect and remain willing to learn from experience. Many of the most effective examples of healthcare emerge through iterative implementation, drawing on insights, learning from those who have led the way and consistently placing the person and service user at the centre of what we do.

I would also like to acknowledge the staff and leadership teams across each of the five pilot sites. Their generous contributions to this programme of work have been instrumental in shaping this practical toolkit, as a support for future hub locations.

The need for enhanced, holistic postnatal services is well documented, from the National Maternity Experience Surveys (NMES) to the MAMMI (Maternal health And Maternal Morbidity in Ireland) study led by Dr Déirdre Daly. By adopting an iterative approach and capturing the lessons learned during this initial phase of implementation, we can help ensure that the needs of mothers in the early postnatal period are supported and prioritised.

With the continued support of the Department of Health and our HSE colleagues, we look forward to further strengthening and evolving the postnatal hub network. We remain committed to listening to, and learning from, both those who provide care and those who receive it.

*Angela Dunne, Director of Midwifery, National Women and Infants Health Programme.*





## Abbreviations

<i>Clinical Midwife Manger</i>	<b>CMM</b>
<i>Community Health Organisation</i>	<b>CHO</b>
<i>Cork University Maternity Hospital</i>	<b>CUMH</b>
<i>Early Transfer Home</i>	<b>ETH</b>
<i>General Practitioner</i>	<b>GP</b>
<i>Health Information and Quality Authority</i>	<b>HIQA</b>
<i>Healthcare professionals</i>	<b>HCPs</b>
<i>Heath Service Executive</i>	<b>HSE</b>
<i>Information Technology</i>	<b>IT</b>
<i>Key Performance Indicators</i>	<b>KPIs</b>
<i>Minding yoU and Me Always</i>	<b>MUMA</b>
<i>National Maternity Experience Survey</i>	<b>NMES</b>
<i>National Maternity Strategy</i>	<b>NMS</b>
<i>National Women and Infants Health Programme</i>	<b>NWIHP</b>
<i>Portiuncula University Hospital</i>	<b>PUH</b>
<i>Public Health Nurse</i>	<b>PHN</b>
<i>Sligo University Hospital</i>	<b>SUH</b>
<i>University Hospital Kerry</i>	<b>UHK</b>
<i>Whole time equivalent</i>	<b>WTE</b>
<i>Women's Health Taskforce</i>	<b>WHT</b>
<i>World Health Organization</i>	<b>WHO</b>



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## Summary Overview

### Introduction

Internationally, high quality postnatal care is recognised as ensuring the health and wellbeing of mothers, infants and families. The postnatal period is considered an opportune time to positively impact women's and infant's health in the short and long term. Robust and accessible services enable the early detection and treatment of health concerns, while continued contact supports health monitoring and access to informational, emotional and practical care. Maternity care services and healthcare professionals play an essential role in providing for women's and infant's needs during this time of change, challenge and vulnerability, to support them to, not only survive, but to thrive.

The publication of the Health Information and Quality Authority's (HIQA) National Maternity Experience Survey (NMES) 2020, found that many women giving birth in Ireland have a positive experience with maternity care services, however, a number of areas for improvement were identified. In particular, women reported a noticeable reduction in the standard and provision of care in the postnatal period in comparison to antenatal care. Disappointment with the lack of informational, practical, and emotional support from trusted and experienced healthcare professionals in a community setting was repeatedly expressed. Additionally, the need and appetite for enhanced and expanded one-to-one care, increased availability of midwifery-led services, support, and counselling, and debriefing services were reoccurring themes identified by the NMES (2020).

In response to the findings of the NMES (2020), and in line with National Maternity Strategy (2016) the National Women and Infants Health Programme (NWIHP) began to take action towards enhancing postnatal care through the development and launch of five Postnatal Community Hubs in Ireland. The aim of the Postnatal Community Hubs was to ensure equitable access to a comprehensive and multidisciplinary package of postnatal resources, healthcare services and professionals, with a woman-centred ethos, and from community-based facilities for the duration of the postnatal period.

Five pilot sites were identified through an application process. The services that are offered at each pilot location were developed with consideration for service needs, such as local birth rate, geographical spread, and population demographics, and resource availability, such as funding, staffing and physical amenities available at each site. Throughout the service development and implementation process the NWIHP endeavoured to form a collaborative partnership between the



Directors of Midwifery and healthcare staff at each of the pilot sites to support co-operative learning, identification of difficulties, and expedite solution finding.

This novel approach to service implementation prompted the need to develop a guide for the deployment of Postnatal Community Hubs in Ireland.

### *Aims of the ‘good practice guide based on lessons learned’*

The ‘good practice guide based on lessons learned’ is informed by the expertise of multiple healthcare professional stakeholders involved in the establishment of the five pilot Postnatal Community Hubs. The guide aims to provide a practical resource with advice and recommendations for other healthcare professionals aspiring to establish Postnatal Community Hub services in other localities in Ireland. Additionally, in recognition of regional differences and resource variability, the guide was formulated to offer guidance and support rather than prescriptive requirements.

## Key findings and recommended actions

### *Overarching recommendation*

The implementation of principles from each section should be considered at the outset of service development, and a plan of action should be established, in consultation with the ‘good practice guide’ and relevant local stakeholders prior to commencing the launch of services or allocation of resources. A key consideration is to approach the establishment of a Postnatal Community Hub as necessarily involving an iterative and collaborative process.

The following findings and recommended actions are divided by three sections

- i. Preparatory Work
- ii. Learning and Adapting
- iii. Sustaining and Building.

### *Preparatory work*

Substantial time should be invested at the outset of the development of a Postnatal Community Hub into extensive planning and preparatory work. Though enthusiasm and a desire to provide much needed services may motivate action, care should be taken to ensure a true understanding of local needs, develop strong leadership and inter-professional relationships, and establish cooperative understanding between stakeholders involved in relevant referral pathways.



The successful implementation of services will benefit from:



- Developing a Vision Statement and business case plan: A Vision Statement will bring a cohesive ethos and description of the motivation for the service to the project, while a business case plan offers a structured process for translating the vision into action and real services.
- Establishing strong inter-professional relationships early and with the intention of on-going respectful collaboration: Forming open and on-going communication pathways with healthcare professionals already embedded in postnatal community care is an essential and non-negotiable step which underpins the success of the Postnatal Community Hub. Communication should expand beyond notification; it should include genuine collaborative roles established before the launch of services. Maintaining positive inter-professional working is vital; collaboration should be approached as a continuous process in the development, and re-development or improvement, of the Postnatal Community Hub services.
- Integrating existing resources and services: A comprehensive business case plan will support identification of local population needs, existing and established resources; human and structural, while inter-professional communication may assist in identifying additional community resources.
- Developing and testing referral pathways to and from the Postnatal Community Hub with the assistance and input of professionals providing care in the local hospital and in the community.
- Identifying and supporting leadership among the Postnatal Community Hub staff, and external 'Champions' who may encourage inter-professional 'buy in'.
- Establishing a continuity model of advertising the Postnatal Community Hub's services through design of bespoke materials and distributing materials to promote awareness of the services among women throughout their pregnancy and postpartum journey. Locally specific advertisement may also be held within a nationally unified brand/identity that is shared among all Postnatal Community Hubs.
- Developing a data collection, analysis and evaluation plan at a local and national level.

### *Learning and adapting*



Learning and development during the implementation process of the Postnatal Community Hub benefitted from the unique collaborative learning and partnership structure established between the NWIHP, the Directors of Midwifery at each pilot site, and two Director of PHN representatives. On-going communication was facilitated through regular forums and all-site progress updates. Additionally, Directors of Midwifery and core staff were encouraged to network with and to visit other pilot sites to facilitate shared learning. This approach helps to drive motivation, encourage healthy competition between sites and supports collaborative learning and information sharing which positively benefits service development.



It is recommended that:

- The NWIHP leadership continue with individual one-to-one, on-site, meetings at each Postnatal Community Hub to support understanding of, and solution finding to, individual challenges experienced.
- The all-site forums are continued at a reduced frequency to support continued collaborative learning and working, encourage the healthy competition that has supported service development thus far, while avoiding unintentional comparative evaluations among Postnatal Community Hub at different stages of development.
- Directors of midwifery and the NWIHP may support and facilitate new opportunities for active networking and visitation between Postnatal Community Hub sites.

Midwifery roles within the Postnatal Community Hub required a broader understanding of postpartum health, infant health and wound healing than individuals providing midwifery care typically encounter or require.

Postnatal Community Hub staff may be supported through:

- Organisation of training days to expand on clinical knowledge, examples include ‘Examination of the New-born’ training, wound management, and lactation support.
- Inter-professional education sessions to provide HCPs with greater knowledge of the roles and remits of their professional colleagues, to help them understand appropriate referral criteria and pathways, and how to identify when women/ service users are suitable or unsuitable of certain pathways.

### *Sustaining and building*

To ensure that the progress made by the Postnatal Community Hubs is sustained, and to support the expansion of services to other locales, several recommended actions are suggested:



- Current and proposed Postnatal Community Hubs should continue to lead the development of services at individual sites. This will ensure that local needs and resources are considered and tailored to site-specific capacities.
- However, site-specific capacities should not negate the need for standardising core service provision across sites. For example, Postnatal Community Hubs’ staff made two suggestions, based in an assessment of women’s postnatal health needs. First, that existing hubs would benefit from the allocation of additional funding to provide women’s health physiotherapy services where there currently are none, and that a women’s health physiotherapy role be featured as a core service provision requirement of all future Postnatal Community Hubs, with dedicated funding.



- Current and proposed Postnatal Community Hubs may be supported by the NWIHP taking a leadership and guidance role in areas such as establishing a minimum resource allocation package expected within proposal applications (for standardising core service provision), standardised information leaflets and national branding/identity, standardised expectations for data collection and analysis, and setting National Guidelines for implementation of services. This will ensure uniform standards of implementation which will support equitable access to resources across locations.
- Continued and invigorated focus on promoting inter-professional collaboration and communication will serve to support positive relationships between professionals providing the Postnatal Community Hub services and professionals currently embedded in community care.
- Data collection, analysis and evaluation of services were identified by staff at each of the pilot sites and by NWIHP leadership as an area requiring improvement. First steps may include establishing core KPIs and minimum data set collection. In addition to regular service user satisfaction evaluations to inform service development and improve service delivery.



## 1. Introduction

### *1.1 Developing the good practice guide: aim and processes*

In 2021, the National Women and Infants Health Programme (NWIHP) began taking steps towards developing five Postnatal Community Hubs in Ireland. The development of resources specifically to address postnatal care was in response to the findings of the Health Information and Quality Authority (HIQA) National Maternity Experience Survey 2020, which demonstrated that postnatal care is an area identified by women as requiring improvement.

Working in collaboration with the maternity networks in Ireland and the Department of Health's Women's Health Taskforce, the Postnatal Community Hubs were envisaged as a comprehensive and multidisciplinary package of resources. The aim of the Postnatal Community Hubs was to ensure equitable access to healthcare services and professionals, and provision of community-based, woman-centred, multidisciplinary healthcare resources for the duration of the postnatal period.

Directors of Midwifery were invited to submit proposals and NWIHP, in 2022, identified and approved funding for five pilot sites where the Postnatal Community Hubs were established. Throughout the service development and implementation process of the Postnatal Community Hubs, NWIHP endeavoured to form a collaborative partnership between the Directors of Midwifery and healthcare staff at each pilot site to support co-operative learning, early detection of complications and facilitate solution finding.

This is a novel approach to service implementation in Ireland, which also supported NWIHP's goal of developing a guide for the deployment of Postnatal Community Hubs in Ireland. A guide informed by the experiences and lessons learned by the healthcare professional stakeholders involved in the establishment of the five pilot sites. This document 'Establishing Postnatal Community Hubs in Ireland: A good practice guide based on lessons learned' is the realisation of that goal.

This good practice guide is intended to bring the expertise of professionals who established and are managing and working within the postnatal hub services together with the experiences and expertise of other healthcare professionals providing postnatal care within the community who work alongside and refer women and their babies to the hub services. It aims to provide a practical resource with advice and direction for other healthcare professionals aspiring to establish Postnatal Community Hub services in other localities in Ireland.

This guide was developed following a series of meetings with the Directors of Midwifery from each of the five pilot Postnatal Community Hub sites, and relevant colleagues involved in developing or providing services within their respective Postnatal Community Hub. In addition, four meetings were held with the corresponding sites' Directors of Public Health Nursing, Assistant Directors of



Public Health Nursing and relevant Public Health Nurse (PHN) colleagues. Two meetings were conducted with physiotherapists, and one meeting was conducted with a General Practitioner. One meeting was conducted with leadership from the NWIHP involved in the implementation of the Postnatal Community Hubs. All meetings were conducted online and lasted between 60 and 250 minutes [average 90 minutes]. Meetings were held with a total of 36 maternity care professionals and project managers. An interview/meeting guide, which contained minor amendments for each healthcare professional, was purposefully developed to structure the meetings and shared with all in advance of their meeting. The interview/meeting guide was developed to capture information in relation to motivations, practical operational processes, inter-professional relationship and network building, hidden challenges and opportunities, incremental service alterations or adaptations, and overall lessons and knowledge accrued through the process of establishing a Postnatal Community Hub (Appendix 1).

The processes for implementing a Postnatal Community Hub outlined here are both general and specific, rather than linear description of the steps involved. Through integration of the lessons learned from the establishment of the five pilot Postnatal Community Hubs, this document aims to offer non-prescriptive guidance that are intended to be tailored to the different infrastructures and resources available in each locality, while accounting for differences in service demands implied by diverse catchment areas and populations served by local maternity hospitals.



## 2. Background

### *2.1 Women's health in the postnatal period*

Whilst many women enjoy excellent health during and after pregnancy, some women experience health problems that significantly and negatively impact on their medium and long-term physical and mental wellbeing, quality of life, relationships and ability to experience motherhood in positive health. Some women experience health problems prior to pregnancy that are exacerbated by pregnancy and childbirth, while for others, health problems may emerge, persist and even worsen long after they have given birth.

The identification and treatment of maternal morbidities has gained much attention in the international literature. There is growing acknowledgement that maternal mortality is a narrow indication of the effectiveness of maternity care and services, and that the extent and consequences of maternal health problems, or maternal morbidities, have been overlooked.

The prevalence, impact, and importantly, solutions for detecting and treating medium and long-term maternal morbidities has received less research and policy attention, and resource allocation than maternal mortality over the years (Vogel et al., 2024). However, the personal, social and economic benefits of ensuring that women may avail of reliable and accessible postnatal healthcare is becoming increasingly evident (Finlayson et al., 2020; Hannon, Newnham, et al., 2022).

The reported prevalence of maternal morbidities varies widely and is dependent on the definition used, and the timing of measurement. However, systematic analyses of available literature shows that substantial proportions of women experience medium-to-long term morbidities beyond 6-weeks postpartum. For example, prevalent conditions include dyspareunia or pain during sexual intercourse (35%), low back pain (32%), urinary incontinence (8- 31%), anxiety (9- 24%), faecal incontinence (19%), and depression (11 - 17%). Perineal pain (11%) and secondary infertility (11%) are also common morbidities (Vogel et al., 2024).

Irish-based data collected from women giving birth in Ireland between 2012 and 2017, shows that a high number of women report persistent sexual health issues at six months postpartum, such as a lack of vaginal lubrication (43%) and dyspareunia (37.5%) (O'Malley et al., 2018). Urinary incontinence was reported at 31.5% at three months postpartum and 20.9% at six months postpartum (Daly, 2014). While a range of other health issues such as extreme exhaustion (68.2%), back pain (57.8%), hemorrhoids (35.5%), constipation (34.1%) and bowel problems (38.1%), pain and infections of cesarean section wounds (17.5%) and perineum wounds (30.2%), and breast



health problems (41.8%) are highly prevalent up to three months postpartum, and remain a burden for some women 12 months after giving birth (Hannon et al., 2023).

International reports for postnatal depression are reported at 9.5%-18.7% (Woody et al., 2017), and prevalence estimates of depression from Irish-based data in the first postpartum year (14.2%) aligns with findings from other high-income countries (Hannon, Gartland, et al., 2022). Maternal suicide is the leading cause of direct deaths in the United Kingdom and in Ireland (Knight et al., 2022; O'Hare et al., 2018). The most recent MBRRACE report unveiled concerning developments within UK and Irish data, as the risk of suicide during pregnancy and the first six postpartum weeks was found to have tripled in the year 2020 in comparison to previous years (Knight et al., 2022). Worryingly, this increase is in line with a general trend that pre-dates the Covid-19 pandemic (De Backer et al., 2023).

Other researchers have shown that physical and mental health morbidities may persist far beyond the first year postnatal. For some women urinary and fecal incontinence remain unresolved as long as four years after giving birth (Gartland et al., 2016), pelvic girdle pain has been reported to persist even twelve years postnatal (Bergström et al., 2017). Longitudinal research illustrates persistently high proportions of depression (24.7%), anxiety (32.6%) and stress (26.1%), five years after the birth of a first child (Bryson et al., 2021).

Experienced alone, any one of these physical and mental health issues represents a considerable burden and barrier to enjoying motherhood in positive health. However, health concerns are not experienced in isolation and research also demonstrates the cumulative effect of health problems on other areas of life and function. For example, urinary incontinence is associated with postnatal sexual dysfunction (Badreddine et al., 2022), reduced quality of life (Van der Woude et al., 2015) and depressive symptoms (Fritel et al., 2016). Persistent pain hinders women's ability to engage in the maternal role in the way they wish to (Wuytack et al., 2015), and negatively impacts her mental health (Shepherd, 2005). The negative consequences of mental health problems on women's relationships, their physical and mental health, and the physical, social and cognitive development of their children (Slomian et al., 2019), is well documented in the literature. Moreover, maternal morbidities represent a significant long-term economic burden for women, families, the health system, and society (Bauer et al., 2016; Moran et al., 2020; Rokicki et al., 2022).

## *2.2. Postnatal healthcare provision*

### *2.2.1 Postnatal healthcare provision in an international and Irish context*

From an international perspective, postnatal care and services have been described as the most neglected aspect of maternity care provision and generally receives less attention than antenatal and intrapartum care. Criticisms include level and scope of service provision, duration of care and quality



of care (Barimani et al., 2015; Bick et al., 2020; Buultjens et al., 2017; Jenkins et al., 2014; Johansson et al., 2019; Larkin et al., 2012; Malouf et al., 2019; Miller et al., 2014; Ong et al., 2014; Sacks & Langlois É, 2016; Woodward et al., 2016).

In 2022, the World Health Organization (WHO) published a guideline on positive postpartum care (WHO, 2022). This guideline aimed to improve the quality of essential, routine postnatal care for women and new-borns with the ultimate goal of improving maternal and new-born health and well-being. It recognised a “positive postnatal experience” as a significant end point for all women giving birth and their new-borns, laying the platform for improved short- and long-term health and well-being. A positive postnatal experience is defined as one in which women, new-borns, partners, parents, caregivers and families receive information, reassurance and support in a consistent manner from motivated health workers; where a resourced and flexible health system recognises the needs of women and babies and respects their cultural context.

The Maternity and Infant Care Scheme outlines the schedule of antenatal and postnatal care that is provided, free of charge, to all pregnant women who are ordinarily resident in Ireland<sup>i</sup>. During pregnancy, women may avail of six combined or shared care appointments alternating between her general practitioner and a maternity unit/hospital. Following birth, the scheme provides two postnatal appointments with a general practitioner, one at 2 weeks postpartum to assess infant health and one at 6 weeks postpartum to assess the health of both the infant and mother. Alongside this service provision, some maternity hospitals have developed community midwifery services and Early Transfer Home (ETH) schemes postnatally. However, the availability of these services, and the duration of follow-up care offered, varies nationally. In addition, some of these services offer care only to women who are deemed have no medical or obstetric risk factors.

The conclusion of care, for mothers’ health, at six weeks postpartum, in Ireland and many other countries, reflects a conventional assumption that most physical health concerns associated with pregnancy and childbirth will resolve, and that mental health concerns will have emerged, within this timeframe. Yet, the evidence demonstrates that women experience physical, sexual and mental health problems that emerge and persist long after standard postpartum care has concluded. Additionally, researchers, on behalf of the WHO, focused on the neglect of labour and birth complications that can emerge or persist months or years postnatally and identified the historical limitation of postnatal care services to 6-weeks after birth as a contributing factor (Vogel et al., 2024).

This limitation is also identified in Irish-based research. The conclusion of postnatal services at 6-weeks comes before women have had the opportunity to assess their own health needs and identify if they want or need professional support (Hannon, Newnham, et al., 2022). This introduces two additional barriers to positive postpartum health; first, if women require access to healthcare beyond this timeframe they often must bear the financial costs for their care (Hannon, 2024). Second; access

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<sup>i</sup> Health Service Executive, Maternity and Infant Care Scheme.  
<https://www.hse.ie/eng/services/list/3/maternity/combinedcare.html>



to services beyond the 6-week provision is gained predominantly via General Practitioners (GPs), which again may be costly for women, especially for those with limited means, and presents an issue around knowledge and pathways of referral, as some GPs may not be aware of appropriate referral pathways for a variety of postnatal health concerns (Hannon, 2024). Moreover, women giving birth in Ireland express that the current model of postnatal care is ‘baby-focused’ with little or no attention paid to mothers’ health concerns (Daly et al., 2021).

### *2.2.2 The National Maternity Experience Survey*

Ireland’s first National Maternity Experience Survey (NMES) was conducted in 2019 and was designed to be completed when women were approximately three months postpartum. Two reports on national findings were published; one of these reported on all in-hospital care, including early postnatal care in hospital, and the second reported on findings of women’s experiences of maternity care provided in the community by general practitioners, practice nurses and midwives (HIQA, 2020a, 2020d). In addition, reports on each of the 19 maternity hospitals findings (HIQA, 2020c) and the nine community health organisations’ responses to the findings, were published (HIQA, 2020b).

A total of 6,357 women were eligible to take part and 3,204 (50.4%) responded. Overall, the majority of women had a positive experience of care but others did not, and a number of areas for improvement were identified.

There were a number of higher-scoring responses to the questions where most women reported a positive experience. The majority of the women reported that they were treated with respect and dignity throughout their maternity care journey and had confidence and trust in the staff that cared for them, both in hospital and community settings. They also felt that they had their questions answered and were given information on who to contact about their own or their baby’s health following discharge from hospital. However, a number of lower-scoring questions were identified. Postnatally, some women reported, or commented, that were not given the opportunity to ask questions and be involved in decisions about their care. Other topics that scored low related to access to emotional support and assistance with infant feeding, especially breastfeeding. HIQA found that these lower-scoring questions had a strong relationship with how women rated their overall experience of maternity care. A number of women who responded to the survey commented on staffing levels and the difficulties they sometimes experienced in accessing assistance from staff when they needed it, especially in hospital postnatally. HIQA also noted that some women reported that did not receive enough information on mental health supports both before and after their baby was born.

Notable differences in care experience were found between various participant groups. For example, women who had previously given birth gave more positive ratings of their overall experience than



primiparous women. There were some differences between the scores received by maternity units or hospitals, but in general these differences were relatively small, with most scoring close to the national average for each stage of care and for all topics. There were also differences by participants' county of residence.

The area and topics that scored lowest overall were in relation to postpartum care and services, especially in the community following discharge from hospital.

For example, the survey identified national variation in attendance at the 2-week postnatal check-up. At the 6-week postnatal check-up, most women said that their GP, practice nurse or midwife answered their postnatal questions in a way they could understand, however, many felt that insufficient time was spent discussing their physical and mental health. The responses to the three free-text questions provided very detailed information on women's experiences with their GPs, practice nurses and midwives during their postnatal maternity care in the community and highlighted their need for more personalised care.

Overall, the findings from the NMES (2020) demonstrated clear gap in care and services with regards to postnatal care.

The National Maternity Experience Survey (NMES) also included three free-text questions which invited women to share aspects of their care that were positive, aspects that could have been improved, and aspects of their maternity care that had not been addressed directly by questions in the survey. Participants submitted a total of 6890 comments to these three questions. HIQA's permission was sought to review these questions and include relevant details and quotations as part of the background to this report.

Reflecting only on comments associated postnatal care, the qualitative data revealed seven issues of postnatal healthcare provision that affected women's wellbeing negatively. These areas were identified by bringing together features of postnatal care that women emphasised as needing improvement, alongside aspects of care that some women noted that they had, or would have, benefitted from in the postnatal period. This was an intentional approach to the qualitative data, which aimed to identify problems in postnatal care provision and support solution finding by recognising current strengths that may be leveraged and extended.

These areas occasionally overlapped and include:<sup>ii</sup>

*1) A noticeable reduction in the standard and provision of care in the postnatal period in comparison to antenatal care.*

Under-staffing in the hospital and its effect on care was a reoccurring observation that was noted in relation to the immediate postnatal period and was also an issue for community care

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<sup>ii</sup> Supporting data may be found in Appendix 2



provision. Women were concerned by the lack of healthcare professional availability at a time when they require reliable informational and emotional support, and described this barrier as causing fear, bewilderment and frustration.

*2) Unclear or inefficient pathways of referral/access to appropriate healthcare professionals and acute services for maternal physical health issues, such as infections or haemorrhage, in a timely manner.*

Some women described experiences of receiving conflicting information from maternity services about access to acute services postnatally, leading to distress and delay in receiving critical care.

*3) Beyond 6-weeks postnatal, extensive referral wait times, gaps in referral processes, or no healthcare professionals on staff for mental health and women's health physiotherapy services meant that some women went without care or had to access healthcare at considerable personal cost.*

Again, under-staffing in women's health physiotherapy and specialist perinatal mental health services meant that appointments and care for serious health concerns were not received. Some women accessed care privately at considerable personal expense, whereas others were unable to, which in some cases led to deteriorated health.

*4) Women found the current model of maternal postnatal care provision to be inadequate to their needs, as there were few pathways to accessing postnatal care and care was often narrowly focused.*

Women receive a visit at home from a public health nurse within 72 hours following discharge from a maternity unit, with follow-up appointments in the home or at local clinics at varying time-points dependant on need. Additionally, women receive a six-week postnatal health with a GP. However, women described rushed appointments and infrequent enquiries from healthcare professionals about their own health and common postnatal health issues. Additionally, women found that postnatal care was almost exclusively baby-focused with little attention given to, or healthcare professional awareness of, women's own physical and mental health. The need for additional, woman specific, postnatal appointments was routinely highlighted, as was the need for access to healthcare professionals who have a particular focus on maternal health issues.

*5) Postnatal care that is specifically for the baby's health is often inflexible to the circumstances and needs of mothers and their babies.*

For example, women who had caesarean sections or premature infants were particularly vulnerable to the inflexibility of the current system. Travelling to appointments at community clinics was not feasible for women following caesarean surgery and worrying for women with preterm



infants. Women described being instructed to attend clinics or hospitals, or unannounced home visits, which can lead to distress, strain, and missed care.

*6) Following discharge from hospital the lack of informational, practical and emotional support in a community setting in relation to breastfeeding, child health and maternal health was a recurring issue.*

When women had concerns about their own health or their baby's health there were, often, insufficient available resources where they could direct their enquiries. Women remarked on the need for guidance and support when navigating life with a new-born and the absence of resources where they could access or ask relevant healthcare professionals for trustworthy advice and support. The lack of postnatal breastfeeding supports was especially conspicuous when contrasted with the public health promotion of breastfeeding as the optimum choice for new-born health. Difficulty in accessing the time and expertise of lactation consultant's immediately after birth and in the community was a recurring theme. Women suggested support phone lines, more frequent home visits, and access to a broader range of healthcare professionals to support them and promote confidence in their competence as a caregiver.

Women also provided examples of postnatal care and resources that worked well for them, where they had access to informational and emotional support that enabled them to navigate the uncertainties of motherhood with more confidence, and which was delivered in a way that worked for them. DOMINO care and other community midwives' schemes were a leading example of positive postnatal care among women's comments in response to the question of 'what was particularly good about your maternity care?' These schemes enabled women to have degrees of continuity of midwife carer and be provided with professional and reliable informational and emotional care from the security and comfort of their homes in the postnatal period. These could be accessed in the form of in-person home visits as well as telephone consultations. Currently, the DOMINO care scheme is only available in certain areas and from certain maternity units to women who are deemed to have a normal-risk pregnancy.

*7) Debriefing services are wanted and needed by those who did not receive them, and deeply beneficial to those who did.*

Women's comments addressed the need for, and the value of, debriefing services to assist them in processing and understanding the events of their labour and birth. Additionally, several women mentioned that a debriefing should occur at a time when women are fully able to direct their attention to the information shared.

The evidence demonstrating the extent and persistence of medium and long term maternal morbidities, coupled with the conclusion of postnatal healthcare services to 6-weeks postpartum,



indicates that women are not currently supported by a postnatal healthcare system that can identify, respond to and treat women's health concerns, leaving women unsure of where to go, or who to ask about receiving trustworthy, reliable postnatal healthcare for their own health (Hannon et al., 2023). Therefore, there is a pressing need for robust, accessible and responsive postpartum healthcare provision to meet and treat women's health problems in Ireland.

### *2.3 Establishing Postnatal Community Hubs: The National Women and Infants Health Programme's (NWIHP) role*

In response to the results of National Maternity Experience Survey, and research illuminating the limitations of and barriers to accessing postnatal healthcare services, the National Women and Infants Health Programme (NWIHP) initiated a plan of action towards developing Postnatal Community Hubs with the aim of ensuring access and provision of community-based, woman-centred, multidisciplinary healthcare resources in the postnatal period. The concept of the Postnatal Community Hubs emerged from a series of exploratory discussions, analysis of international models and consultation with national stakeholders.

In partnership with maternity networks and the Department of Health's Women's Health Taskforce (WHT), in 2021 the NWIHP identified funding for the establishment of five pilot Postnatal Community Hubs around Ireland. Alongside this, the NWIHP developed a 'Framework for Enhanced Postnatal Care in the Community' which outlined the strategic vision and development plans for establishing the Postnatal Community Hubs. The framework was underpinned by a desire to design and deliver postnatal care services that support and enable *all* women and their babies to thrive, through extended access to maternity health services that are specialised in providing tailored care in the postnatal period. The framework envisaged the Postnatal Community Hubs as a 'one stop shop' for all women, regardless of their care pathway, pregnancy risk or health insurance status, where they might access multiple services provided by a range of healthcare professionals operating from the same facility. These services included core midwifery care, lactation and infant feeding support, parent education, perinatal mental health support, bereavement support, and birth reflection services. Additionally, the framework aimed to develop postnatal community hub services that i) retained direct access to relevant emergency maternity services and ii) facilitate streamlined and effective referral services to appropriate specialists. Overall aiming to create flexible services, and service access, tailored to each woman's health and support needs. The framework further outlined a plan to evaluate and assess the impact and value of Postnatal Community Hubs through a range of Key Performance Indicators (KPIs) such as number of referrals received, number of onwards secondary referrals made, re-admission rates to hospitals, breastfeeding rates, number of postnatal education sessions, number of outreach visits, level and range of support groups established and qualitative feedback of women's experiences of services.



The NWIHP announced the intention to fund these Postnatal Community Hubs in 2022 to a forum composed of the national Directors of Midwifery in Ireland. Subsequently, the NWIHP issued a formal call for proposal submissions from Directors of Midwifery interested in establishing their area as a pilot site for one of the Postnatal Community Hubs.

Proposals broadly entailed an outline of the local catchment, services and target population, a vision for the development and scope of the Postnatal Community Hub within the locality, timelines for implementation, and a description of the resources, funding and staffing allocations required to successfully implement the new postnatal services.

Six applications were received and five sites were selected. The five pilot Postnatal Community Hub sites are located in: Cork University Maternity Hospital in County Cork, St Luke's General Hospital in County Kilkenny, University Hospital Kerry in County Kerry, Portiuncula University Hospital in County Galway, and Sligo University Hospital in County Sligo.

### *2.3.1 Profiles of the five pilot sites*

The Postnatal Community Hubs were conceived as a multidisciplinary package of resources providing postnatal care within the community. The geographical spread, population demographics, resource and staffing availability vary by pilot site and proposal submissions accounted for these differences with regards to the proposed vision for local service development and requests for resource allocation. For this reason, the number of physical community-based clinics and the range of postnatal services offered, differ site to site.

Currently, the five pilot Postnatal Community Hubs operate between 2-5 community-based clinics in various locations within the catchment of their maternity hospital, and each one was set-up to respond to the needs of the women in their catchment area.

#### **CUMH Women's & Infants Health HUB: *Cork University Maternity Hospital, Cork***

As part of the part of the South/Southwest Hospital Group, there are approximately 6500 births per year at Cork University Maternity Hospital (CUMH), which provides maternity care to women all over Munster.



The Women's & Infants Health HUB commenced services in December 2022. Operating from CUMH and two locations in Cork City, the HUB has implemented several postnatal services intended to form the basis of a 'one stop shop' for postnatal women and their babies. These services provide routine postnatal care, in addition to tailored care for parents which may include breastfeeding



support, a birth reflections service, a debriefing clinic, women's health physiotherapy services, and a 'drop in' clinic for general postnatal support. The Women's & Infants Health HUB provides care to both primiparous and multiparous women and their babies from the point of hospital discharge to 6 weeks after the birth.

### **The MUMA Postnatal Hub: *St Luke's General Hospital, Kilkenny***



The MUMA (Minding yoU and Me Always) Postnatal hub offers support services to mothers and their partners living in the Carlow/Kilkenny area and who have given birth at St Luke's General Hospital.

The MUMA Hub offer new-born screening when local PHN services not available, a seven day-a-week (9 am- 4 pm) phone/text line operated by a qualified midwife, group support sessions and a drop-in Coffee, Chat and Check service facilitated from two outreach locations, online classes, and one-to-one sessions to support birth reflections, individual wellbeing and referrals to relevant healthcare professionals. Additionally, the hub utilises social media platforms to foster a personable connection between the hub and services users, by keeping women up-to-date on service provisions and staff on-duty.

### **Postnatal Hub: *Maternity Services University Hospital Kerry, Kerry***

University Hospital Kerry (UHK) serves a wide geographical catchment area encompassing both urban and rural areas. With a birth rate of approximately 1300 per year, a diverse population and poor public transport infrastructure, the Kerry Postnatal Hub purposefully planned and implemented a 'hub and spoke' model to ensure accessibility and continuity of postnatal care to all women in Kerry.



The inaugural 'Hub' commenced services with the Tralee Postnatal Hub in January 2023, and subsequently opened four 'spoke' outreach clinics at four locations; Listowel, Dingle, Killarney, and Cahersiveen over the following nine months. The Hub and spoke postnatal services are operated based on local population needs, and individual clinics are scheduled once per week to once per fortnight. All mothers and babies of UHK are offered a Postnatal Hub appointment at discharge, regardless of care pathway, at a location of their convenience. The Postnatal Hub offers in-person, phone and virtual appointments according to preference. General postnatal care services include a postnatal assessment of mother and baby, birth debrief, postnatal education, infant feeding/lactation support and wound management. Referrals to bereavement care, perinatal mental



health services, and women's health physiotherapy services are supported. The Kerry Postnatal Hub are currently awaiting the appointment of a women's health physiotherapist.

### **Enhanced Postnatal Services: *Portiuncula University Hospital, Galway***



Portiuncula University Hospital (PUH), located in County Galway, serves a catchment area covering East Galway, Westmeath, North Tipperary, Roscommon and Offaly. The birth rate for this area is between 1300 and 1400 per annum.

Services, which commenced in October 2023, provide postnatal care to both primiparous and multiparous mothers from three outreach clinics located in

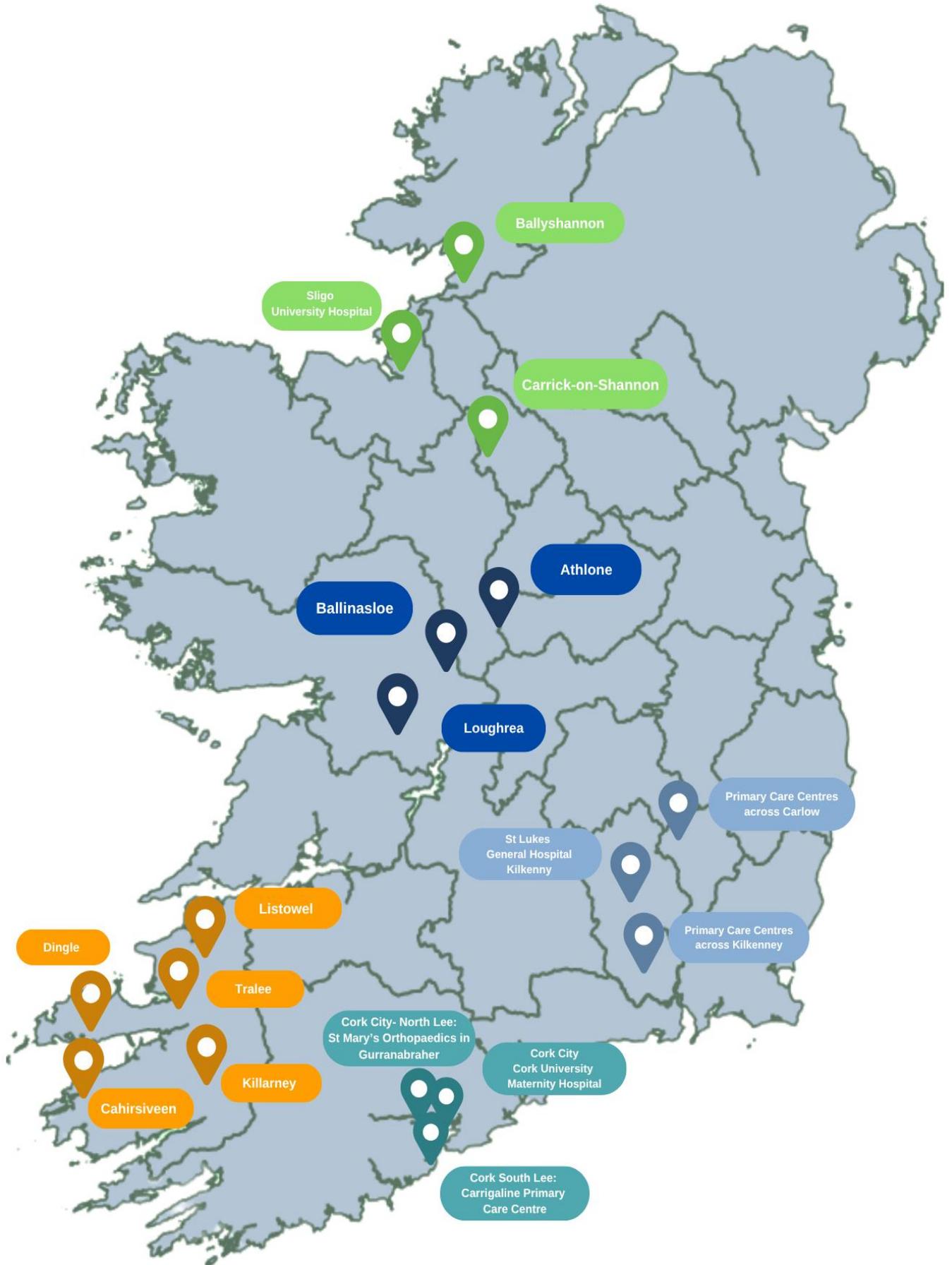
Athlone, Ballinasloe and Loughrea. Upon discharge from hospital, a Hub midwife offers all women giving birth at PUH an in-person postnatal appointment at a clinic that is the most convenient for women. Each in-person appointment includes a 45-minute appointment with midwife and entails a head-to-toe check of both mother and baby to assess recovery and emotional and physical well-being. The Enhanced Postnatal Services also offer weekend clinics, to accommodate women's needs, onsite at PUH and a dedicated daily phone line staffed by a qualified midwife.

### **Postnatal Enhanced Care SUH HUB: *Sligo University Hospital, Sligo***

Maternity Services at Sligo University Hospital (SUH) provides Maternity care to women from the catchment areas of Sligo, South Donegal, Leitrim, West Cavan and North Roscommon.

Postnatal Enhanced Care hubs commenced in November 2023 and are located at four Primary Care Centres already providing midwifery-led supportive care in Carrick on Shannon, Ballyshannon, Ballymote, and Sligo. Services include a postnatal clinic appointment offered to all women between 8-20 days after birth. Each appointment consists of a one-hour consultation with a midwife, and involves a full physical check for the mother (Mummy MOT) and her baby. Appointments may involve an optional birth debriefing service, health promotion/ education and feeding assessment. Referrals and follow-up care are provided as clinically required. Additionally, a midwife provides telephone postnatal support during designated hours, Monday to Friday.







### Cork

**Cork City- North Lee:**  
St Mary's Orthopaedics in Gurrabraher

**Cork City:**  
Cork University Maternity Hospital

**Cork South Lee:**  
Carrigaline Primary Care Centre

Approx. 6500 births per year

- 3 WTE Midwives
- 1 CMM2
- 1 WTE Physiotherapist
- 1 WTE Administrative Support Officer

Drop in service (3 days per week, 8 am- 4 pm).  
Birth reflections.  
Physiotherapy services  
Coffee, Chat and Check service.

### Kilkenny / Carlow

**St Lukes:**  
General Hospital Kilkenny

**Primary Care Centres:**  
across Carlow

**Primary Care Centres:**  
across Kilkenny

Approx. 1300 births per year

- 1 WTE CMM 2
- 0.5 WTE clinical physiotherapist specialist
- 3 WTE midwives
- 1 WTE Administrative Support Officer

Phone line (7 days per week, 9 am- 4 pm)  
Check in phone call at three weeks postnatal.  
Coffee, Chat and Check service.  
Drop in service (2 days per week)  
Virtual Classes  
Physiotherapy services

### Kerry

**Listowel**

**Dingle**

**Tralee**

**Cahirsiveen**

**Killarney**

Approx. 1000 births per year

- 2.8 WTE Community Midwives
- 1 WTE Health Care Assistants

In-person, phone, and virtual appointments  
Postnatal assessment of mother and baby  
Assessment of infant weight  
Birth debriefing  
Infant feeding support  
Referral to bereavement care, infant feeding support, perinatal mental health service, women's health physiotherapy

### Galway

**Athlone**

**Loughrea**

**Ballinasloe**

Approx. 1300 births per year

- 3 WTE Midwives
- 0.5 WTE Administrative Support Officer

In-person appointment: Head to toe check for mother and baby for all women.  
Phone hotline assessment for all women.

### Sligo

**Sligo University Hospital**

**Ballyshannon**

**Carrick-on-Shannon**

Approx. 1200 births per year

- 1 WTE CMM2 Postnatal Hub
- 1 Midwife
- 0.5 WTE Administrative Support Officer

Drop in Service  
Telephone Service  
Referral from Postnatal Ward  
GP Referral  
PHN referral



### 3. A guide to establishing Postnatal Community Hubs

The guide is structured in 3 sections; i) Preparatory Work, ii) Learning and Adapting, and iii) Sustaining and Building. Although presented as three sections, each contains key principles that are relevant and linked throughout the implementation process. For example, lessons learned after the pilot services were already launched may be beneficial if applied at an earlier stage by those seeking to establish new postnatal hub services. Additionally, the dynamic processes of learning from experience, listening to feedback from services users, service providers and all other healthcare professionals means that a bespoke consideration for actions may be required in each locality. Therefore, the steps outlined herein should be considered at the outset.

#### 3.1 Preparatory work

Thorough planning and preparatory work lays the foundations for successful implementation of services. While a degree of ‘learning on the go’ is expected, allocating substantial time to identification of all preparation tasks is vital to avoid losing time and potentially beneficial resources once services have commenced.

##### 3.1.1 Motivation and vision for services

A foundational step for developing and implementing new services is establishing a clear motivation of what one hopes to achieve with the new Postnatal Community Hub service provision and a clear understanding of and vision for how the new services will align with and complement, or replace existing services.

In the case of the Postnatal Community Hub pilot sites, motivations were driven by recognition that postnatal services were not always meeting women expectations or needs fully. The Directors of Midwifery in all five sites shared a common desire to i) develop and enhance women’s postpartum care while simultaneously reducing demands on other services (e.g., re-attendance at/contacting the maternity hospital with follow-up concerns), ii) provide better access to postpartum care for groups not reached or best served within their existing services, and iii) develop an integrated model of care that extended continuity of *care* and/or continuity of *carer* from the antenatal period to the postnatal period *within the community*.

Additionally, the Directors of Midwifery felt that extended postnatal services might offer midwifery staff an opportunity to fulfil their scope of practice thereby reinvigorating morale within the midwifery profession. Enthusiasm for their role and confidence in the benefits of the service were clearly evident in feedback from staff, both midwives and physiotherapists, employed in the Postnatal Community Hubs.

*‘I feel setting up the postnatal hub service in [the community] has allowed me to feel enthusiastic and proud to be a midwife and to reenergise my commitment to midwifery.’*



*'I am immensely proud of the service we are providing and the feedback from women tells us we are doing a good job. The key lessons I have learned is collaboration, collaboration, collaboration and if we put the women at the core and front of the service at all times, we won't go wrong. The service we are providing is different to other areas and that is ok. We are flexible and adaptable and excited to see how the hubs may develop over time.'*

### How To: Developing a Vision Statement and business case plan

A Vision Statement, developed in consultation with all healthcare professionals who are involved in providing postnatal care, may be integrated into a detailed plan of action or business case plan, to bring the vision into real services. Composing a business case plan offers a structured process for refining each site's vision for their Postnatal Community Hub.

Overall, a business case plan should provide sufficient details to present a unified and realistic vision of the Postnatal Community Hub, how it will be integrated with existing services and aligned with care offered by other healthcare professionals, the resources in place or required for its realisation, and the means of assessing quality of care.

A business case plan enables a consideration of;

- The ethos of (Vision Statement) for the new Postnatal Community Hub services.
- The geographical service area and the service users to be served and/or targeted.
- Current service provision and possibilities for addressing services users' unmet needs
- Mapping a woman's care and interactions with maternity services throughout the pregnancy-birth-postnatal care continuum, and identifying what is working well/not well.
- The services that will be provided by the Postnatal Community Hub, including mapping a woman's journey from hearing about and accessing the Community Postnatal hub, to discharge from the Hub.
- How new services will replace, support or complement existing services.
- Prior established resources (infrastructure/ professional affiliations/ electronic referral or appointment systems) which may be utilised or amended for use by the Postnatal Community Hub.
- Key healthcare professionals and a plan for establishing inter-and intra-professional communication and collaboration pathways.
- Referral pathways to the Postnatal Community Hub.
- Referral pathways from the Postnatal Community Hub to key healthcare professionals and other healthcare services.
- How professional roles within the Postnatal Community Hub will replace, support, interact with or complement postnatal services offered by key healthcare professionals.
- Risk minimisation and risk management or contingency processes.



- Additional resources and equipment required.
- Staff training needs.
- Timelines and milestones.
- Metrics/data collection and evaluation of services.
- Branding and advertising of the new Postnatal Community Hub.

**Tip:** It will be beneficial to initiate contact with all healthcare professionals who offer care and services to postnatal women, and other stakeholders, ideally prior to completing the business case plan. Consultation with all relevant healthcare professionals and stakeholders will help inform an understanding of local service provision, identify strengths and areas for further development in current service provisions and local service concerns (from healthcare professionals and women) that may influence the development of the Postnatal Community Hub. Other professionals such as Information Technology (IT) team members can inform on digital resources or technologies that may be available for use by the Postnatal Community Hub, such as scheduling software, or virtual appointment platforms. Actively seeking communication and collaboration with all potential stakeholders simultaneously serves to strengthen new relationships and the business case plan.

Finally, it may be beneficial to seek the expertise and guidance of a business case manager or project officer in the development of the business case plan.

### *3.1.2 Inter-professional relationships: Early engagement for respectful communication and effective collaboration*

The extent of contact that women will have with healthcare professionals in the postnatal period depends on the services available in the area where she lives. The Maternity and Infant Care Scheme provides two GP visits in the postpartum period, one for the baby's health at two weeks postpartum, and one for both the baby's and mother's health at six weeks postpartum (Department of Health, 2016). Additionally, a public health nurse (PHN) should visit women within 72 hours of discharge from hospital to check both woman/mother and infant (Giltenane et al., 2022). The PHN visit is considered a mandatory component of postnatal health service provision; however, meeting every woman's needs within the PHN services is contingent on staffing levels (Phelan et al., 2018).

Therefore, understanding the services and the specific professionals delivering postnatal services in your locale is essential to map how the Postnatal Community Hub will integrate with existing services and, importantly, to plan how Postnatal Community Hub staff may develop mutually respectful relationships with professionals in your area.



### *How to:*

Establishing early communication and fostering open and on-going communication pathways is a crucial and non-negotiable step in ensuring a respectful, inter-professional and collaborative relationship between the Hub staff and Hub service provision and healthcare professionals already embedded in postnatal community care.

Lessons learned while establishing the pilot Hubs revealed several useful strategies for effective intra-and inter-professional relationship building. These strategies may be customised to the needs and resources of each locale; however, relationship building should i) occur as early on in the implementation process as possible and before any service is developed, ii) aim to establish long-term professional relationships, and iii) aim to establish mutually respectful professional relationships.

Importantly, successful communication and relationship building was underpinned by achieving a mutual understanding of roles among all healthcare professionals. This was achieved by clearly communicating that the purpose of the Postnatal Community Hub was to enhance and complement services and that there was no intention to encroach on other healthcare professionals' roles. Therefore, a careful consideration of how each instance of communication may demonstrate recognition of and appreciation for healthcare professionals' roles and welcomes their perspectives was an ideal approach in achieving this aim.

The strategies below blend approaches that worked well for the pilot Hubs, along with advice gleaned from 'lessons learned'.

### ***Establishing communication early:***

- 1) Directly notify local leaders in key healthcare professions about the pending implementation of the Postnatal Community Hub.

Initial communication should contain:

- Introductions, an outline of the purpose of the Postnatal Community Hub, the scope of services envisioned, and vision for integrating the Hub with existing services.
- Acknowledgement of the scope of postnatal care provided by the specific healthcare professional, and vision for how the Postnatal Community Hub services will complement/ support each healthcare professional's role in providing high quality care to postnatal women.
- A clear invitation for feedback, discussion and queries from all healthcare professionals and colleagues.
- A request for a personal meeting, to establish the relationships and enable further communication and collaboration as the hub develops.



- A request to mutually develop a schedule of regular meetings.
- 2) Host an information-sharing/ collaborative event for key healthcare professionals in the locale where the Postnatal Community Hub will be established.
- This may be a short in-person, online or hybrid event involving/inviting multiple professions such as GPs, PHNs, community midwives, obstetricians, paediatricians, hospital staff, and women's health physiotherapists, and specialist perinatal mental health service staff.
  - The information-sharing event may involve a short presentation from the Postnatal Community Hub staff detailing the scope of services envisioned, and plans for integration with existing services followed by an open-to-the-floor discussion session.
  - The discussion session may be structured, with specific questions or areas of concern pre-defined. This process may benefit from a co-design and collaborative approach to service development, with input from all key stakeholders. For example, inviting the healthcare professionals' views on proposed referral pathways and their suggestions for more efficient alternatives.
- 3) Request and arrange for some Postnatal Community Hub staff to role-shadow some key healthcare professionals as they deliver postnatal services.
- It may be particularly helpful for some Postnatal Community Hub staff to spend 2 to 3 days role-shadowing PHNs who provide postnatal care in the community.
  - This will involve the Director of Midwifery at the Postnatal Community Hub contacting and confirming consent with the appropriate healthcare professionals and line managers, and approving and facilitating nominated Postnatal Community Hub staff to allocate time to role shadowing.
  - Role-shadowing offers a unique opportunity to gain in-depth and practical insight into the day-to-day provision of local services from another healthcare professional's perspective, and an understanding of the extent and impact of challenges they may encounter while providing care.
  - Role-shadowing may help identify areas of overlap and differences between the PHN-provided services and the services envisioned for the Postnatal Community Hub. This in turn serves to foster mutually respectful professional relationships, by recognising the value of their community-based roles; additionally it ensures that services are developed to be complementary and supportive while driven by a shared desire to provide woman-centred high quality care.
- 4) Be considerate of intra-professional communication: Midwives, who are employed within the hospital where a Postnatal Community Hub is based, may also find that their professional roles are affected by the implementation of new services. For example, some pilot Hubs expressed that their new services were regarded with some worry and concern, particularly



where new services involved a midwife or midwives moving from services *within* the hospital (an area experiencing significant staffing problems) to the postnatal Community Hub services. Thus, the development of a new service was viewed as, potentially, removing resources from an area experiencing high demands.

- Internal communication and information sharing opportunities should be utilised to convey the vision, scope and significance of the Postnatal Community Hub services for women and babies' wellbeing.

### ***Maintaining communication pathways:***

Once relationships and communication pathways have been opened, they should be nurtured. Maintaining positive relationships and active engagement from other healthcare professionals and stakeholders supports continued growth and improvements for the Postnatal Community Hub.

This is particularly important when the Postnatal Community Hub becomes the integrated point of contact between the acute setting of the maternity hospital and community and vice versa, and because areas for service amendment may be identified after implementation.

#### *How to:*

Monthly meetings with multiple key stakeholders promote on-going professional contact and continued investment from healthcare professionals. Face-to-face meetings assist in developing relationships, while the use of virtual platforms ensures that staff working off site may join from their areas of work, while providing time conscious flexibility to all professionals.

Other actions that aided in maintaining positive relationships varied depending on the healthcare profession in question.

For example, some pilot Hubs found that presenting regular 'progress updates' at GP information nights hosted by the local maternity hospital and providing GPs with 'business cards' containing the contact details and list of services available within the Postnatal Community Hub was useful to ensure continued awareness of the Hub and encourage outreach.

Additionally, other pilot hubs reached a mutually agreed approach with PHNs in the form of providing updates on referrals made by PHNs to the Postnatal Community Hub. This 'feedback' pathway extended beyond formal structured referral processes and served to provide PHNs with confidence that women they had cared for were receiving the appropriate supports for their health concerns, while also demonstrating the benefits to women that resulted from integrated inter-professional co-operation between the hub and PHNs.



### *3.1.3 Planned integration with existing resources and services*

General and maternity care service community-based resources differ by location in Ireland. Some areas had an established community midwifery presence whilst others did not. Those that did not have an established presence in primary care centres/settings were sometimes challenged in securing suitable, and regular and on-going access to, health service premises. A comprehensive assessment of local needs, existing and established resources, human and structural, and plans for seamless integration between existing and newly developed services will assist in positive developments in this area.

#### ***Integrating the Postnatal Community Hubs with Early Transfer Home Schemes (ETH).***

Some pilot sites had a DOMINO and/or Early Transfer Home (ETH) scheme already in operation prior to the development of the Community Postnatal Hub.

The majority of maternity hospitals/units in Ireland operate an ETH services that are led and delivered by midwives. The ETH services originated as a solution to an increase in the number of women birthing in Ireland, the resulting demand on postnatal beds, and the need to discharge home early those women who were assessed as being low-risk who could safely have follow-up postnatal care at home. Core components of high-quality maternity care underpinned the development of this scheme; for example, continuity of care by a midwifery team, individualised one-to-one postnatal care for the mother, community-delivered care, and timely facilitation of access to specialised postnatal care and referrals. Postnatal care within the ETH scheme entails discharge from the maternity unit, often within 24 hours of birth, followed by postnatal care delivered by a community-based midwife in a woman's home, generally up to seven days post discharge. Further visits are tailored based on each woman's individual needs, and may vary from one to five home visits, until a woman is discharged to the care of her local public health nursing service.

However, ETH services are resource intensive and so the services are provided to limited geographical ranges. Additionally, ETH services are primarily available to low-risk women who experienced spontaneous vaginal and birth without complications, therefore excluding women who experienced pregnancy, birth or postnatal complications who may benefit from such follow-up care and services. Overall, while these are services may be beneficial for all postnatal women, a relatively low percentage of all women giving birth annually are eligible to avail of the scheme. Finally, while the ETH was developed and delivered with high standards of care in mind and is regarded by the healthcare professionals providing services as beneficial to, and well received by, women, the ETH scheme services were not evaluated to assess cost and service effectiveness, or optimal allocation of resources.



The existence of previously established ETH schemes presented what could be viewed as a challenge while developing the Postnatal Community Hubs for two reasons:

First, the Directors of Midwifery viewed the ETH schemes as providing high-quality and valuable services and did not wish to see the schemes, or the investment made in their development, made redundant by the implementation of a Postnatal Community Hubs. Rather the Directors of Midwifery were motivated to ensure that the ETH schemes and the Hub services were integrated effectively to serve the greatest number of women, and make the resources that were already in place, more efficient.

The addition of a new postnatal care provision caused a degree of confusion for some healthcare professionals working within the hospital and in the community, and for service users. For example, some healthcare professionals struggled to know and understand the inclusion and exclusion criteria, the differences between the referral criteria for the ETH and Community Postnatal Hub service pathways, and the methods of communicating these pathways to women as the service users. This was a challenge that was especially evident in the early days of the Community Postnatal Hub development.

Whereas some women were confused as to the purpose and eligibility criteria of multiple postnatal service pathways and, importantly, choosing the pathway that would provide them with the most support, and be the most beneficial to their postnatal recovery and needs.

Reconciling the motivation to maintain the ETH scheme services while ensuring that care pathways were clearly differentiated and communicated to both healthcare professionals and women was a key learning point for the Directors of Midwifery and the professionals involved in establishing the Community Postnatal Hubs.

The initial approach taken was through the development of clearly defined differences in service pathways which was communicated to healthcare professionals and women in the form of reference materials. This was followed by integration of the Postnatal Community Hub with the established services over time, so that women may avail of a wider range of resources, best suited to their needs, in the postnatal period.

Determining suitable eligibility criteria for each postnatal care pathway required drawing on professionals' experience and clinical judgement to ascertain which women would most benefit from home visits from community midwives or the supports and services offered by the Community Postnatal Hub. Reaching a conclusion on this issue of eligibility and true integration of services was supported by continuous communication and iterative revaluation with and between healthcare professionals in the community and the Postnatal community Hub.



### ***Assess local needs***

An assessment of the geographical service area and the demographics and needs of service users to be served and/or targeted will help in understanding what facilitators and barriers are involved in women's ability to attend or engage with the services offered by the Postnatal Community Hub. For example, hubs that cover larger or more rural geographical areas will need to consider how women will be able to travel to hub appointments. Key considerations are the cost and reliability of local public transport and the added barrier of arranging childcare for older children for multiparous women. Timing of appointments and mode of birth should also be considered, for instance women who have had a caesarean section will not be able to drive themselves to appointments for at least six weeks after surgery. Therefore, in-person appointments scheduled before this time may lead to inadvertent exclusion of some women from accessing services. Additionally, early or morning appointments may be unrealistic for women adjusting to the demands of new motherhood, or women who must ensure that their other children attend school on time.

Planning each hub's services will also require a thorough understanding of the socio-economic and ethnic diversity of the local population, as this may call for additional resource requirements to ensure equitable access for all women.

Understanding the strengths and weaknesses of existing services, and how the services of the Postnatal Community Hub will be integrated at a service and inter-professional level is best achieved through early collaboration with healthcare professionals already embedded in the community. Key professionals, such as PHNs and GPs can offer an in-depth perspective of local needs, provide detailed knowledge of current service provision within a community setting and identify the met and unmet needs of service users. Additionally, insight from such healthcare professionals will inform strategies for integrating the Postnatal Community Hub services with existing care pathways.

### ***Utilise existing resources***

Prior established resources (infrastructure/ professional affiliations/ electronic referral or appointment systems) may be utilised or amended for use by the Postnatal Community Hub. In the case of the Postnatal Community Hub sites and available maternity care, some pilot sites had antenatal outreach clinics and therefore physical buildings in the community where clinics were located. Utilising existing physical clinic sites was identified as a strategy to promote timely implementation and economical use of resources. This may require negotiation for access and use of physical clinics. Providing antenatal and postnatal care at the same local clinics also evokes a sense of continuity of care for women. Therefore, this challenge may be turned to an opportunity towards steps to integrating care across the whole care continuum.



### 3.1.4 Referral pathways

The business case plan will involve mapping the services that will be provided by the Postnatal Community Hub, a plan of how services will replace, support or complement existing services as well as a description of referral pathways *to* and *from* the Postnatal Community Hub. Ideally, this mapping of services and development of referral pathways will be informed by early collaboration with all healthcare professionals who have contact with women in the postnatal period. However, it is also important to develop services and referral pathways from the perspective of the woman's care experience to reduce the risk of 'missed connections' with regards to the different care pathways women may need to avail of and ensure that postnatal care best fits women's needs and circumstances.

#### *How to:*

Referral pathways (outlined in the business case plan) may be developed with the following considerations:

- Have individual referral pathways (both *to* and *from* the Postnatal Community Hub) been developed in consultation with relevant healthcare professionals? (Such as PHNs, Physiotherapists, Mental Health midwife, Specialist Perinatal Mental Health Team, Obstetrician, Paediatrics, Lactation Consultants).
- Have relevant healthcare professionals been provided with a referral pathway diagram or document?
- Has the 'flow' of referral pathways been tested? A clinical flowchart showing the exact process of what happens when a woman enters and leaves the Postnatal Community Hub services.
- Is there a process through which healthcare professionals may flag concerns about gaps or weakness with referral pathway after it has been implemented?
- How soon after being referred to the Postnatal Community Hub will a woman receive an appointment?
- When and how do women first hear about the Postnatal Community Hub services?
- Is there flexibility around the cut-off times when a woman can be referred to (and access services of) the Postnatal Community Hub?
- Is there a pathway for women to 're-connect' to the Postnatal Community Hub if she reconsiders an initial decline of services?
- Will the Postnatal Community Hub establish an informal referral pathway to community groups (Mother and baby groups, breastfeeding support groups, Family Resource Centres) to promote on-going community-based postnatal support while and after availing of the Postnatal Community Hub services?



### *3.1.5 Team building: Champions and Leadership*

#### *Champions:*

A Postnatal Community Hub will require the effective integration of new services with existing services. Therefore, identifying key healthcare professionals whose workloads will be impacted by the development of new services and engaging with them to establish inter-professional ‘buy-in’ can support the successful implementation of new services.

Establishing ‘buy-in’ from other healthcare professionals may be assisted by an inter-professional ‘Champion’. The inter-professional champion/s may support engagement between the Postnatal Community Hub staff and key healthcare professionals and play an integral role in positive integration and expansion of services.

Identifying an inter-professional ‘Champion’ who is ‘external’ (not employed within) to the Postnatal Community Hub services extends beyond establishing communication and relationship building. The PHN profession provided the primary example of a strong inter-professional champion among the pilot Hubs.

Effective champions were individuals who:

- Had professional experience related to the development of new service pathways.
- Understood the ethos of the Postnatal Community Hub, and its service provision goals, and was capable of communicating these values and goals to all their colleagues.
- Were provided with, and encouraged to use, pathways to relay when processes were ineffective, and to give advice on alternatives.

#### *Leadership:*

Service implementation endeavours are made successful through the expertise and co-operation of a multi-disciplinary team. Effective leadership leverages the strengths of all team members to ensure that professional skills may be utilised to the benefit of service development and service users.

Though the Director of Midwifery at each site was responsible for the overall implementation of services in their area, progress was strongly supported by one or more ‘internal champions’ or leaders within each Postnatal Community Hub. Establishing multiple leadership roles within the Postnatal Community Hub enabled a lateral style of leadership and collaborative working. This further fostered a positive working environment in which team members felt enabled and encouraged to make suggestions and take the initiative to implement change for service and quality improvement (alongside regular implementation team meetings, evaluation and progress management reports).



The internal champion/s or leader/s within the Postnatal Community Hub hold a vital role in the successful development of services.

Effective internal champions were individuals who:

- Recognised the importance of inter-professional collaboration and fostered positive relationships with healthcare professionals whose professional roles were affected by the implementation of Postnatal Community Hub.
- Had strong active listening, communication and negotiation skills.
- Were solution-finding focused.
- Actively supported communication pathways between inter-professionals and the Postnatal Community Hub.
- Operationalised feedback from stakeholders into service change and improvements.

### *3.1.6 Branding, marketing and social media*

The healthcare professionals at each pilot site took differing approaches to branding and marketing the new Postnatal Community Hub services, and to social media use. Some did not formally advertise the development of new services, while others spent considerable time visualising how branding and social media might be utilised to promote awareness among other healthcare professionals and the general public. The differences in approaches were influenced by the resources that each site was able to secure in this endeavour.

However, on reflection of the lessons learned throughout the process of establishing the services, the Directors of Midwifery at each site endorsed the benefits of a unified image and promoting the Postnatal Community Hub as a distinct service.

The following are some approaches that ‘worked well’ and recommendations for the continued development of Postnatal Community Hubs.

#### *1) Continuity of advertising*

A continuity model of advertising emerged as an effective method for promoting the Postnatal Community Hub. Some hubs focused on ensuring that women were made aware of their local Postnatal Community Hub at multiple time points through their pregnancy and postpartum journey. Several hubs carefully planned their advertising materials, and timing and distribution of materials to promote wide awareness of the Hub among women and healthcare professionals locally.



Some actions involved:

- The development of a physical Postnatal Community Hub information leaflet/ pamphlet/ service menu, which also contains access to the same information in a digital format (via QR code or shortened URL).
- Distribution of physical and digital Postnatal Community Hub information materials at antenatal classes. Additionally, copies were made available for maternity hospital waiting rooms, and for local GPs to distribute in GP practice waiting rooms.
- Women received a physical information leaflet/pamphlet/service menu directly from a hub-based midwife while they were on the postnatal ward, alongside a verbal introduction/explanation of the services that are available.

2) *Create a brand identity that reflects the Postnatal Community Hub's values.*

One pilot hub created individual branding that promoted a message of being inclusive, open and honest about the difficulties of motherhood, while also providing a safe space with genuine listening and care. This site centred their branding on the message that the woman's/mother's health was the primary focus and purpose of the hub's services. Additionally, this branding and messaging was underpinned by Irish research that detailed the experience, and consequences, of a lack of healthcare professional support in the postpartum period for women giving birth in Ireland (Daly et al., 2021; Hannon, Newnham, et al., 2022).

The development of branding at this particular pilot site was supported by additional funding awarded through the Health Service Executive's (HSE) Spark Innovation Programme. This entailed the development of a visual logo and a Postnatal Community Hub name (MUMA – Minding You and Me Always).

The pilot hub created physical marketing materials such as:

- ❖ Business cards for healthcare professionals, which promoted awareness of and referrals to the Postnatal Community Hub.
- ❖ A Postnatal Community Hub 'Service Menu', a high-quality pamphlet with information for mothers, fathers and families about what Postnatal Community Hub is, and what it is not, and what services and supports are provided. The service menu provides a QR code for digital access to the Postnatal Community Hub's service information.

Additionally, staff at this pilot site carefully considered the purpose of the Postnatal Community Hub's social media presence during the service planning stages. The implementation team decided that the purpose of the hub's social media account was to:



*Remind women of the hub's services:* In the business of parenthood, social media posts regularly remind women's/ service users about weekend services and dates, times and locations of in-person, drop in groups sessions.

*Signpost women to services and evidence-based resources:* Social media posts are used to direct women to other reliable and trustworthy healthcare and information services available to them

*Create a personal connection:* The hub's team use social media posts to update women/ service users on the exact midwife 'on-duty' at the hub on any particular day. This puts a friendly face to service delivery while also promoting continuity of carer as many women meet one or more of the Postnatal Community Hub's midwives on the postnatal ward before discharge.

*Meet women where they are:* Facilitating online messaging addresses changing patterns of technology use, as younger mothers may be more comfortable sending messages through social media applications rather than making phone calls to ask for advice or help.

### 3) *Creating a nationally unified brand/identity among all Postnatal Community Hubs*

The branding and marketing that implementation teams utilised was largely determined by the resources and expertise available at each pilot site. However, the unique model of co-operative learning supported by the NWIHP in the establishment of the five pilot Postnatal Community Hubs may be used to facilitate the expansion of effective marketing and branding techniques from one site to other and future sites.

Creating a nationally unifying brand or identity to be shared among all Postnatal Community Hubs is a recommendation that is endorsed by the Directors of Midwifery at each pilot site. The need for a unified identity was based on the rationale that a clearly maintained identity may also provide clarity for women/service users across regions. For example, some women may give birth in one Postnatal Community Hub's catchment but access postpartum services provided by a different Postnatal Community Hub. Uniform branding may help to ensure that women know what is available to them, and do not have to 'navigate' service differences by region.

A cohesive national identity may serve two supplementary purposes. First, uniform branding may demarcate the Postnatal Community Hubs as purposefully fulfilling a specific service gap. In other words, a uniform national image may visually demonstrate an active response coming from governmental and organisational levels in addressing women's postnatal healthcare needs in Ireland. This shared brand or identity may aid in communicating service improvements to healthcare professionals, women/service users, and the general public.



Additionally, the teams at each pilot hub stated that they would welcome the implementation of a nationally unifying image and felt it should be supported by the leadership of the NWIHP. They believed that a shared image would serve to progress standardisation of services across sites and equally recognise the contributions made by staff at each site.

### *3.1.7 Planning for data collection, analysis and evaluation*

Data collection, analysis and evaluation of services were identified by each pilot Hub and by NWIHP as an area requiring improvement moving forward.

There were a number of barriers to establishing evaluation plans in the development of the pilot Hubs:

- A majority of staff employed at each pilot site are clinical professionals with self-identified limited experience in service evaluation processes.
- Diversity between each pilot site in terms of resources, staff and funding allocations, geographical spread and service demands (i.e. differences in number of births per year) impeded a standardised method of evaluating service provision and comparison between sites.
- Some sites recorded reference metrics such as number of contact points, number of appointments and referrals to and from their Postnatal Community Hub. However, these were not uniformly collected and some sites stopped collecting metrics at times when staff members were overwhelmed with service provision.
- Each site initiated some form of service user satisfaction survey. However, these were developed by and for each specific pilot site and not compared across sites.

### *Recommendations:*

The following recommendations are developed from lessons learned combined with approaches that worked during the implementation of services.

- *Leadership and expertise:* Having an experienced midwife with knowledge of service implementation was advantageous in all the pilot sites. These midwives, whether their role was Clinical Midwife Manager 2 (CMM2) or Advanced Midwife Practitioner (AMP), worked closely with/alongside the Directors of Midwifery to create the vision for the Hub, lead on its implementation and any revisions required to service delivery. In order to document service effectiveness and services users' satisfaction, Directors and senior midwives in each site should plan, *a priori*, the KPIs to be measured. This may support the consideration of building clinical research capacity locally. While most staff employed within the Hubs are



clinical professionals, it is acknowledged that some clinical professionals' remit, e.g. AMPs, include research commitment.

*Data collection and evaluation of services:* In addition to identifying KPIs locally, the evaluation of the Postnatal Community Hubs at a national level may benefit from the creation of a standardised minimum data collection set, this minimum dataset will consist of pre-identify metrics that will be collected at each site irrespective of resource level or task-load volume. The minimum dataset should contain three strands that enable an evaluation of the following areas: Satisfaction with services, Extent of service provision and Goals achieved. The minimum data set should also enable the Hubs to demonstrate the impact of the new services provided.

1. *Goals Achieved/Reduction of demand for acute services:* Are the Postnatal Community Hub services reducing demand for other acute services provided by the maternity hospital?
  - Reducing demands on acute services was identified as a goal of providing the Postnatal Community Hub services. However, evidence of reduction of demand for acute services and diversion to the Postnatal Community Hub is, to date, anecdotal at each pilot site.
  - Future Postnatal Community Hubs may evidence achieving this goal by including a pre and post implementation log of service use of other acute services.
2. *Extent of service provision:* Are women using the services and are a diversity of women accessing the services?
  - Metrics such as appointments and referrals were not collected uniformly by each site or across time. Points of contact such as phone messaging and phone call services were variably collected, and while advice or support may have been provided via phone or virtual consultations these were not initially noted as clinical care. Additionally, socio-demographic information of women/service users was not collected at any pilot site.
  - Pilot sites and new hub sites may demonstrate the extent of care provided though the implementation of a unified collection framework.
3. *Satisfaction with services:* What is the level of service user and staff satisfaction with the Postnatal Community Hub services and service provision?
  - Each site conducted service user evaluation/ satisfaction surveys during the implementation process which were used to refine the services provided.
  - A standardised evaluation schedule may be useful during the implementation of services for example, quarterly service user evaluations to establish i) satisfaction with services ii) suggestions for change/ improvements to inform the services as they develop and respond to local needs. Alongside, bi-yearly staff satisfaction evaluations and feedback on improvements.



## 3.2 Learning and adapting

### 3.2.1 Collaborative learning and partnership

Following funding approval, the NWIHP endeavoured to establish a collaborative partnership between the Directors of Midwifery at each pilot site in the set-up of the Postnatal Community Hubs, with two Director of PHN representatives. This is a new and novel approach to service implementation. Typically, in Ireland, services have been developed and implemented in isolation, without an oversight or guidance body or opportunities to connect with and learn from other professionals who are also implementing services.

Elements of this collaborative partnership included a quarterly, in-person, forum between NWHIP leadership and all the Directors of Midwifery and core staff from each pilot site. The purpose of these regular forums was to gain progress updates, identify barriers to service implementation, and enable joint problem-solving and co-operative learning between sites. Directors of Midwifery and core staff were encouraged to network with and to visit other pilot sites to facilitate shared learning. Additionally, NWIHP leadership visited each site for one-to-one meetings with the aim of developing a deeper understanding of individual challenges experienced. This approach to collaborative planning, especially across hospitals and regions, is new and was welcomed by all.

The following points outline features of the working partnership that worked well and suggestions for constructive action.

#### *Lessons learned and suggestions for constructive action:*

Individual hub sites identified several positives features of the quarterly forum meetings.

- *Motivation:* The forum meetings helped to sustain motivations to drive the implementation process forward.
- *Healthy competition:* The forum meetings offered a benchmark for comparison of individual progress against progress made at other sites.
- *Co-operative learning:* The forum meetings enabled information sharing and support between hubs. In particular, hubs that had begun implementing services at an earlier date were able to share strategies that helped to resolve barriers and challenges commonly experienced in the initial stages of service implementation. This enabled newer pilot hubs to learn from these challenges and take preventative action.

The forum meetings were valued for offering flexibility and a dynamic learning space which was beneficial and reassuring to hub staff as they navigated a method of joint service implementation that is not common to the Irish health system.



However, while each hub appreciated a degree of healthy competition, progress updates could be a source of discomfort for staff, particularly at times when they were experiencing challenges to progressing the hub's goals. In these instances, staff felt that the progress updates, unintentionally, shifted into comparative evaluations. Inequitable resources, differences in staffing and service demands meant that comparisons could not be made objectively. This feature left some staff feeling that their hub's progress, and their efforts, was unevenly compared to hubs with more resources, lesser workloads or at a more advanced stage of development, which occasionally created a sense of discouragement.

On reflection, it was difficult for forum meetings to facilitate candid and practical conversations relevant to each hub's context and specific difficulties. Therefore, the pilot hubs may have benefited from the introduction of the individual one-to-one meetings with NWIHP leadership at an earlier stage. Staff at the pilot hubs recommend a blended approach going forward, consisting of regular individual meetings, which focus on progress updates and individual challenges, alongside a continuation of the quarterly forum meetings, which focus on information sharing, collaborative learning and joint solution finding.

Staff in some sites actively networked with, and visited, other pilot sites; relationships were described as positive, and information and resource sharing as open and generous. However, heavy workloads and distance between sites were identified as a barrier that precluded a more active engagement in networking and shared learning for other pilot hubs. With this limitation in mind pilot hub staff proposed that the quarterly forum may alternate location for each meeting, so that staff might have a scheduled opportunity to visit each pilot hub on-site.

### *3.2.2 Training and education*

Training needs were identified after the implementation of the services. Midwifery roles within the Postnatal Community Hub required a broader understanding of postpartum health, infant health and wound healing than individuals providing midwifery care typically encounter or require.

The Directors of Midwifery sourced healthcare professionals with the knowledge or skills required to provide training for staff. For example, some Postnatal Community Hub staff wished to develop their knowledge of wound management so that they might understand the healing process, to be able to identify how a wound should look at approximately 2-3 weeks, and to know when wounds should be referred. In this case, the hub employed a tissue viability clinical nurse specialist who provided a learning session to address these questions and more.

Some hubs also benefited from 'Exam of the New-born' training. Additionally, as the midwifery role typically does not extend beyond 1 week postpartum, some staff were unsure of appropriate weight



ranges for infants at and beyond 2-3 weeks old, and a qualified lactation consultant was engaged to share professional knowledge with Postnatal Community Hub staff.

Overall, hub staff expressed that they had a new appreciation for the complexity of postnatal care and while that complexity required new skills acquisition, this was viewed in a positive light. As acquiring new knowledge and skills gave midwives a growing confidence that as they were learning more they were also providing more to the women in their care.

Although not a specific training requirement, midwives providing services in the Postnatal Community Hub's recognised a gap in their understanding concerning other healthcare professional's roles in postnatal care, in particular the role of PHNs and women's health physiotherapists. This sentiment was echoed in interviews with those healthcare professionals and noted as bi-directional. Each group expressed the idea that healthcare professionals often function in a 'siloed' manner, and have only a partial understanding of the skills, role, and scope of expertise that professionals in other disciplines can offer.

Each group also indicated that providing services within, or working alongside, the Postnatal Community Hub offered an opportunity to develop a deeper understanding and appreciation for the skills and care that each professional provided to women in the postnatal period. However, they also indicated that there was continued scope for improvement in this regard and suggested (and were actively working towards providing) practical solutions to address this gap.

#### *Inter-professional educational sessions*

A women's health physiotherapist provided an example of delivering educational sessions to midwives, PHNs and practice nurses on the role of a women's health physiotherapists in postnatal care. Specifically, to increase awareness of what a women's health physiotherapist is, does, and can treat, along with educational sessions on specific health issues that other professionals may not have realised could be addressed by a women's health physiotherapist. Benefits included increased referrals from these professionals and improved communication between physiotherapists, midwives and nurses. In addition, the women's health physiotherapist noted that women benefit from this strategy, as they received referrals in a timelier manner and a close working relationship is perceived in a positive light when a woman's midwife/ PHN knows the physiotherapist and her professional remit.

Both PHNs and midwives working in the Postnatal Community Hubs suggested that implementing inter-professional educational sessions may be beneficial in bring awareness to each profession's skills and remit in postnatal care. It was also suggested that, aside from increasing awareness and professional appreciation, such sessions may also be useful in avoiding over-lapping roles between PHNs and the Postnatal Community Hubs service provision at the point of service design.



### *Student placements*

PHNs, women's health physiotherapist, and midwives working in the Postnatal Community Hubs considered the benefits of introducing student placements. For example, for PHN and midwifery students to spend some time working in the Postnatal Community Hubs, and/or with physiotherapists and vice versa, to gain a better sense of the roles and responsibilities of professionals in different areas of expertise.

### *3.3. Sustaining and building*

#### *3.3.1 Guidance and leadership for expanding the Postnatal Community Hubs*

As previously mentioned, the Postnatal Community Hubs were established using a model of collaborative partnership between the NWIHP and the Directors of Midwifery at each pilot site. Lessons learned from this unique approach revealed several benefits and areas for improvement (section 3.2.1). A question that arose for stakeholders centred on whether the NWIHP should take a governance or guidance role in the implementation of the Postnatal Community Hubs, and in the expansion to new locations around Ireland.

Each pilot site appreciated that they had a large degree of autonomy to develop their services based in an assessment of their local needs; however, they also felt that a standardised approach would be beneficial in some areas, and that the NWIHP may be best placed to assume a leadership role.

For example, the NWIHP may provide or ensure:

- A minimum resource allocation package expected within proposal applications.
- Standardised information leaflets and referral pathways for women.
- Set National Guidelines for implementation of services.
- Structured national branding for the Postnatal Community Hubs.
- Standardised set of data collection metrics, and guidance for methods of collection, storage and transfer of data.
- Data analysis/evaluation of services directed by the NWIHP.

Additionally, as the NWIHP is the guiding body leading the roll out of Postnatal Community Hubs in Ireland, NWIHP may consider providing implementation of service development resource packages and training to all staff involved in the development of each new Postnatal Community Hub site.



These resource and training packages may:

1. Place a strong focus on the importance of the planning and preparation stages. This may be achieved through a revision of the current Postnatal Community Hub proposal/ application. Application processes should ensure that applicants provide in-depth understanding of:
  - Current postnatal services offered by the local hospital (DOMINO, ETH etc.) and how the Postnatal Community Hub service will align with or replace these services.
  - Current postnatal services provided by healthcare professionals embedded in the local community, and evidence of having established communication pathways with these healthcare professionals prior to the application.
2. Integrate the lessons learned from the development of the pilot hubs with implementation framework/ science from Irish-based data/ resources. This may be achieved through the development of 1-2 service implementation training workshops provided to successful applicants following funding approval.
3. Provide each new site with standardised project planning documents.
4. Continue to facilitate the Postnatal Community Hub forums to support collaborative learning, with the suggested amendments (alternating location and changed forum focus).

### *3.3.2 Promoting inter-professional collaboration*

PHNs identified an additional avenue of guidance and leadership that NWHIP may consider when moving forward with the expansion of the Postnatal Community Hubs in new locations. The PHNs who contributed to the interviews expressed sharing the ethos of the Postnatal Community Hubs and recognised the value of the new services to women and, in some cases, the additional support that the services offered to PHNs in their role.

However, several mentioned a desire to have played a larger role in the implementation of services that impacted their professional roles. This was a concern to them as PHNs are the key healthcare professional group embedded within the community providing postnatal care. Additionally, they felt that their expertise in postnatal care could be leveraged to better inform the development of local services and avoid duplication and/or overlap of services between the Postnatal Community Hub midwives and the PHNs' mandated role in postnatal care in Ireland.

Prior to the implementation of the Postnatal Community Hubs, the NWHIP formally informed all Community Health Organisations' (CHO) Chief Officers of plans for the development of the enhanced postnatal care services delivered via the Postnatal Community Hubs. This communication provided Terms of Reference, membership and an invitation to PHN representatives from each area to join the NWHIP's National Network Group. Two PHN representatives chose to join the group.



However, some PHNs teams who participated in the interviews expressed feeling less informed than others about the development of Postnatal Community Hub services. Although PHN teams acknowledged this communication pathway had been extended formally and, in some cases established, they wished to draw attention to barriers they experienced in establishing reciprocal communication, particularly in the early days of launching the Postnatal Community Hubs. For example, changes in PHN management staff in some locations interrupted communication pathways, and PHN workload volume hindered reciprocation in others. The PHN teams urged professionals leading the establishment of Postnatal Community Hubs to be sensitive to communication barriers and ensure all efforts are taken to achieve genuine multidisciplinary partnership in shaping future, seamless and integrated services.

The PHN teams were clear to articulate that their professional priority is to join with the Postnatal Community Hub staff to work in a complementary fashion to support mothers, babies and families as a whole. To achieve this, they welcome the opportunity to be involved at a national and local level at the earliest possible stages of service development. While they would welcome a standardised model for Postnatal Community Hub implementation nationally, they are also receptive to the need for bespoke approaches to account for regional differences. Overall, they are very much interested in contributing to exploring how PHNs, midwives, physiotherapists and other healthcare professionals can achieve integrated services for the benefit of mothers.

### *3.3.3 Standardising core service provision*

Currently, the pilot sites have different resources and offer different services, e.g., the availability of women's health physiotherapy services, and the timing of follow-up appointments. These differences are due in part to the different resources that were requested at the time of application, and to the geographical spread and population volume requiring services. While staff at each site felt that services modified to local resource availability and service demand is a reasonable approach going forward, the Postnatal Community Hub teams felt that there should be a level of core service provision that is standardised across existing and to-be-developed hubs.

The exact core service provision elements may be identified following a consultation process with key stakeholders and is a matter for further development. However, staff at the pilot hubs were in agreement in regard to the need for a women's health physiotherapist. Only three of the five pilot sites applied for funding for a women's health physiotherapist and staff at these locations view this resource as an invaluable asset that benefits women's health and wellbeing. The sites without a women's health physiotherapy service described feeling keenly aware of the absence of this care pathway, particularly in light of the proportions of women they encounter who would benefit from it.



Therefore, Postnatal Community Hubs' staff made two suggestions i) that existing hubs would benefit from the allocation of additional funding to provide women's health physiotherapy services where there currently are none, and ii) that women's health physiotherapy role be featured as a core service provision requirement of all future Postnatal Community Hubs with dedicated funding.

### *3.3.4 National data collection, management, analysis and evaluation*

Issues around data collection, analysis and evaluation of services were identified by staff at each of the pilot sites and by NWIHP leadership as an area requiring improvement. Barriers to establishing evaluation plans, and recommendations for metric domains were previously outlined in section 3.1.7.

The barriers identified at a local level illustrate the need to create a national level role to ensure that sustaining and building the Postnatal Community Hubs are evidence based.

National leadership for service evaluation was endorsed by the Postnatal Community Hub staff. Each acknowledged that high-quality service provision is an on-going process, that services should be objectively assessed, changes made as a response to findings, and assessed again to ensure that changes implemented are effective, and what women want and need.

In terms of evaluating the services offered, it is recommended that, as a first step, all sites come together to discuss and agree the core KPIs and data to be collected, and approach to data analysis. This should be based on identifying the core KPIs already collected as part of routine monitoring of ongoing services, and those that are available from services impacted by the newly established Hubs (i.e., number of women who re-attend or call the hospital for non-scheduled care). Integral to the evaluation is the collection of women's satisfaction with all aspects of the services including the timing, locations and types of services offered. At the outset, all sites should identify a lead professional i.e., a professional with a research remit, to lead and conduct the evaluation.



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## Appendices

### Appendix 1- Semi-structured interview guide

#### Establishing Postnatal Hubs in Ireland: Developing a guide from lessons learned

##### **Motivations and application**

- ❖ Why did you apply for funding?
  - *Opportunity to improve local service provision? Develop personal professional profile? Other?*
- ❖ How did you apply?
  - *Who were the named applicants? Did you receive support, consultation or advice from colleagues/ researchers in developing the application?*

##### **Preparatory work: Communication and collaboration**

- ❖ What were your first steps?
  - *Board, committee or key persons notified. Permissions sought? Collaborations previously or newly established?*
- ❖ Who were your key contacts?
- ❖ How did you establish (initial) communication and collaboration with:
 

· <i>IT Communication departments</i>	· <i>Mental health professionals</i>	· <i>Administrative assistant/support</i>
· <i>Quality and safety</i>	· <i>GPs</i>	· <i>Additional committee members</i>
· <i>Midwives</i>	· <i>Social workers</i>	· <i>Others</i>
· <i>PHNs</i>	· <i>Physiotherapists</i>	
- ❖ How was communication/ collaboration maintained?
  - *How often, and in what way (formal meetings, informal, progress updates, committee established) was contact maintained?*
  - *Did contact maintenance change or develop over time? (What worked and what didn't work, for which groups/ contacts, and why?)*
- ❖ How long after application approval did you begin recruiting for HCP (midwife, WH physiotherapist, admin support) positions within the Hub?
  - *Requirements for positions, Challenges in recruitment*

##### **Preparatory work: Physical resources**

- ❖ How did you secure physical locations for the Hub?
  - *Where were the venues? How many? Frequency of access? Negotiations for access?*
  - *What would you do differently? What advice would you have for others in a similar circumstance?*
  - *Costs and hidden challenges?*
  - *What worked for staff?*
  - *What worked for women?*

##### **Preparatory work: Defining your services**

- ❖ How were the guidelines for your Postnatal Hub developed? Who was involved in development?
  - *Developed based on specific policy?*
- ❖ What determined which services would be provided (initially)?
  - *Limited resources? Staffing availability? Evidence of need?*
- ❖ What was the extent of service provision?
  - *Time to discharge?*
- ❖ Were there structural/ services conflicts between hospital processes and the Hub?
  - *Conflict between other services (DOMINO, Early Transfer Home (ETH)) and PHNs?*
  - *How were these resolved? Any that continue?*
- ❖ Did you have clear pathways of referral prior to launch of the Hub?
  - *Did pathways require any buy-in from other HCPs?*



### **Doors Open: Providing woman-centred care**

- ❖ How did/do you reach/recruit women?
  - Advertising? (through hospital, community, social media, other)
  - Did referral pathways expand or constrict after launch?
  - What changes to reaching/ recruiting women have you implemented over time, and why?
- ❖ What were/are the criteria for eligibility to attend the Hub?
  - Did eligibility criteria change over time? Why, what change and how was change implemented?
  - Did you change service provision to improve access for women? (i.e. unintentional exclusion of women, or reconsideration of pragmatic factors) What changes did you implement and why?
- ❖ Did you change/ develop service provision based on women's feedback or needs?
  - What were these changes and how did they better serve women?
  - What were the challenges to new/ different service provision?
  - What were the benefits to women? Costs/ benefits to staff?
- ❖ How frequently does your Hub elicit women's feedback? What is the mechanism for seeking feedback?
  - Use of standardised form? Satisfaction with services? Electronic or written?
- ❖ Are there services you feel that women want or need, but that the Hub is not currently equipped to provide? How might your Hub be supported to develop these services?

### **Doors Open: Team building**

- ❖ Who makes up the core staff at your Postnatal Hub?
  - What are your Hubs' current recruitment needs?
  - How are appointments to positions within your Hub managed, and by whom?
  - Does your Hub have administrative support for professionals (recruitment, project management, organisation, scheduling etc.)
  - How frequently does the Hub core staff meet?
  - How is communication maintained? (online, in-person, electronic messaging etc)
  - How are decisions within the Hub made? (Top down, Team troubleshooting/problem-solving)
  - Is there an oversight committee? If yes, who are the members?
  - Is the core staff supported to raise concerns, flag issues or make suggestions?
  - What are your main core staff needs? (how might they be better supported to provide service at a high standard)
  - Have you obtained feedback from staff working on the hub? (How? Standardised form, verbal or written feedback? Etc.)
  - If so, how has feedback been used to improve or make changes in the provision of service at the hub?
- ❖ Inter-professional relationship building: What other external HCPs or professionals support the Hub? (IT staff, local GPs, PHNs, PHN managers, community groups for underserved communities i.e. migrant population or traveller community)
  - How were these relationships established? How are these relationships maintained?
  - How does relationship building/ maintained differ by profession?
  - Have you struggled to build relationships with certain groups?
  - Are there professionals or community groups your Hub (and women using the Hub services) would benefit from a closer relationship with?
  - How might your Hub be supported to improve inter-professional relationship building?

### **The Postnatal Hub: Evidencing quality, effectiveness and service use**

- ❖ Are you measuring:
  - Number of referrals into the Hub (and from whom)



- *Frequency of use of Hub services (Number of calls and returned calls, number of attendances, repeat attendance, time to discharge)*
- *Decrease use of other hospital services (i.e. labour ward calls)*
- *Attendance at other hospital services (ER or readmission)*
- *Number of referrals-out (to physiotherapist, lactation consultant, mental health services, local community resources e.g. Family resource centres, Planning for Life, PEIN, Lifestart etc.)*
- *Referral-out reasons (wound infection, mastitis, mental health etc.)*
- *Other demographics on women using services provided in your Hub*
- ❖ If your Hub has a women's health physiotherapist, are they measuring:
  - *Number of referrals (and from who)*
  - *Average time to discharge*
  - *Demographics on women who attend*
  - *Referral onwards*
  - *Number and length of appointments*
  - *Reasons for referral*
- ❖ How are the different metrics within your Hub recorded? (electronic database, paper based)
- ❖ Do you (and the Hub staff) feel confidence in collecting, storing and managing data metrics?
  - *Training needs in GDPR or HRRs? Access to/ licences for data collection software?*
- ❖ Could your Hub benefit from a standardised means of recording metrics?
- ❖ Which women do you feel you need to reach? Why do you feel the Hub has not reached certain women?

### ***The Postnatal Hub: Co-operative learning***

- ❖ How has your Hub been supported by the NWIHP?
  - *Benefits of quarterly meetings, flexibility of meeting formats (online, in-person)*
  - *Clear communication of goals and expectations*
- ❖ How might your Hub be better supported by the NWIHP?
- ❖ Do you feel that there is co-operative learning and knowledge exchange occurring *between* the different Hub teams
  - Have your or your Hub staff liaised or communicated with the other Hub teams *outside* of the meetings facilitated by NWIHP? (*Have you contacted any of the other Hub teams to troubleshoot issues that you have faced? Or been contacted?)*
- ❖ What lessons have you learned about improving communication between groups?
- ❖ How might the different Hub teams better support each other?
  - *Problem solving, resource and knowledge sharing and exchanges, visiting other Hubs?*

### ***What is a Postnatal Hub to you?***

- ❖ How do you define your Postnatal Hub?
  - *By services offered? By the ethos that developed the Hub? Or by an ethos that developed from learning with the Hub?*
- ❖ Do you feel that you have personally and/ or professionally benefited from your involvement with the Postnatal Hub?
- ❖ What do you think are the key lessons you learned about setting up a Postnatal Hub?
- ❖ Are there things you would have done differently knowing what you know now?
- ❖ What things would you do the same?
- ❖ What advice would you offer others setting up a Postnatal Hub?
  - Do you have any further points/ issues, thoughts on facilitators or challenges that you would like to share about: Setting up the postnatal hubs? Service provision? Staffing the hubs? Women accessing/availing the services provided at the hubs?



## Appendix 2- National Maternity Experience Survey (NMES) 2020: Qualitative comments excerpts

### 1) Reduced standard of care and care provision in the postnatal period

- ❖ *Sadly, I found postnatal care quite opposite to antenatal. I felt that as soon baby was born the level of care dipped sharply. I found it bewildering having to explain my situation to a different person at every visit, even though I attended community midwife centre. Being able to build a relationship and trust with one (or few) people would be a lot more beneficial.*
- ❖ *The care while your pregnant is very good and frequent, the care at the hospital is also good, but once you're at home, after a couple of visits from the public health nurse, you are left alone with your questions and the internet to get answers*
- ❖ *Care after birth was not great. After my first baby I felt completely neglected as a first-time mum.*
- ❖ *I feel that midwives are so overworked, and staff shortages are compromising this vital aftercare.*
- ❖ *I believe that all the staff really try their best and give 100% but, at the end of the day, that's all they can give. If the resources are too low, they are under too much pressure and therefore cannot perform to the best of their ability, which isn't fair on them and isn't fair on the patients.*

### 2) Disorganised, unclear, or inefficient pathways of referral/access to services

- ❖ *The aftercare for mothers at home is not great; I've been in pain since birth with a [Cond. Type] and have had to go around in circles to get help.*
- ❖ *My aftercare was horrendous. I started to haemorrhage 11 days postpartum due to a retained placenta. I rang the maternity ward asking could I go to them, and they say no, strictly A&E. So, I had to wait in A&E for 12 hours with a newborn while continually bleeding. I thought the maternity ward was open to you for aftercare for 6 weeks, but I was told that was incorrect.*
- ❖ *The aftercare was scandalous. I was sent home from the hospital on the Friday, and I was told if there were any problems to ring and go straight back over. I got very sick on the Monday and Monday evening and had to go back to hospital. When I phoned the post-natal department, I was told I had to go through A&E. The whole experience was horrific. When my friend had a similar experience in another hospital she phoned and didn't have to go through A&E she was told to present at the ward.*
- ❖ *I wasn't given an opportunity to rest and recover. I spent the first 10 days post-partum traveling in and out of (hospital) - sitting in cars and on waiting room chairs. I ended up getting a really bad infection and was left with a gaping wound in agony.*
- ❖ *After care was shocking, there was no support for me. I had 3 infections after the birth and went to physio in the hospital and was sent to GP. Queued in GP for 3 hours, how the physio couldn't get a doctor to write prescription. Next infection I called A&E and was told 'there is a que, go to out of hours doctor'. So honestly, no after care, you had your baby, goodbye.*

### 3) Extensive referral times, gaps in referral processes, or absence of services

- ❖ *I also contacted the mental health support and was never called back. I ended up asking for help privately. I had to go back 7 weeks after birth because I was in a lot of pain. I was given a prescription and told I would be referred to the physio clinic. I never received the promised appointment letter. The public maternity care in this country is a disgrace. I came across very professional staff as well that were helpless because of the lack of staff to do their job properly.*

- ❖ *There was a mental therapy midwife which helped a lot when I was able to meet her. She moved job and the service stopped. Although she said the phone would be answered by the hospital if I needed, when my baby was admitted in hospital a second time, I got no response to my text asking for help. I am still in need of help mentally.*
- ❖ *I contacted the physio department and was told I would not be seen for 9 months. Completely unacceptable. I went privately to woman's health physio. I still suffer problems. Hospital were zero help.*
- ❖ *The referral rate for physio. I waited 8 weeks and badly deteriorated during this time.*
- ❖ *Aftercare for Mum is very poor. My son is 16 weeks old, and I am still going to the GP and specialists with issues. However, this is all at my own expense post the 6-week check-up.*

#### *4) Insufficient, mother focused, community-based postnatal care*

- ❖ *At my six-week check-up in my GP's I wasn't even asked how I was until I was being ushered out and mentioned my stitches were quite sore and asked her to check them. (I) have still to be asked about my mental health by going who knows background of depression and anxiety.*
- ❖ *During the 6 week check up with my GP I was not asked a single question regarding my recovery (physical or mental). Essentially, I had no check-up once I was discharged from the hospital 2 days post-delivery. I felt like my health status was not important. I had stitches that were never checked if they had healed properly. My GP had no interest in my welfare and I felt as if my baby's check was a box ticking exercise.*
- ❖ *Post-natal care for the mother should stretch beyond 6 weeks. After this time, it is difficult to afford GP visits while on maternity benefit. It is a crucial time in terms of healing, coping, mental health and life changes, contraception etc.*
- ❖ *I think there should be more aftercare for the mother and not just the 6-week GP check-up. I privately went to a women's health physio which I found very beneficial but I would not be a possibility financially for a lot of new mother.*
- ❖ *The 6-week GP check should focus more on the mother too and not just the baby. A 15 minute GP check-up at 6 weeks is not really sufficient to cover everything.*
- ❖ *I think follow up care upon leaving the hospital should be as much about the mother as the new-born baby. The mother's health and well-being (physically and mentally) is paramount in ensuring the health and safety of the new-born baby/babies as well as any other family members involved.*
- ❖ *There is little to no regard for a mother's health and wellbeing after baby is born it is all about baby only...the 6-week check-up is supposed to be for mother and baby but only baby was checked and only questions about the baby no concern if mother is doing or feeling ok...my stitches were not even looked at during this appointment.*
- ❖ *I would have liked a follow-up appointment in the postnatal period after my 6-week check-up. At my 6-week check-up I was still very much still in the 'baby bubble' and a follow-up appointment to check up on my physical and mental condition after this would have been greatly appreciated.*

### 5) Inflexible postnatal care for mothers and infants

- ❖ PHN should do more than one home visit after baby born. Our initial appointment with PHN was a Home visit and after that we had to take our premature baby into the clinic for appointments even though the same service was advising us not to take our baby out in the winter weather or to public places.
- ❖ My public health nurse would not come to see me at my home after her first visit with me at my home. She arrived one day and did not call to say she was coming, to even say what day or time she was coming, I missed her and ever since myself or my partner would have to drive myself and baby to her office to see her, even within the first 6 weeks where you can't drive yourself after the section.
- ❖ No home visit from public health nurse. Had to bring 5-day-old premature baby out to the public health nurse instead.
- ❖ More home visits. I only seen the health nurse once in 3 months.
- ❖ Follow up of PHN nurse could also be improved, arranged follow up visit but cancelled at last minute and never rearranged even after leaving messages.
- ❖ I think more regular home visits from PHN would have been better. I worried, stressed and cried a lot in the first few months and really probably all I needed was someone to reassure me on (what it) is like with a small baby. A public number to call from 9.30am - 10.30am Monday - Friday is not enough - I'm afraid a new baby doesn't fit into that scenario and my GP sends me to the hospital every time I bring him in so that makes me reluctant to see her when again it's probably just reassurance I need that he's ok.

### 6) Insufficient informational, practical and emotional community-based postnatal support

- ❖ After birth care is very poor in the long run. For the first week or two you have support and someone to ask but after that you are reliant on your GP.
- ❖ I think some after care for the postnatal time period of 6 months would be beneficial. I felt supported the first month but after that I felt left to my own devices. I would not have a lot of family support and I would have liked somewhere to go for reassurance apart from my GP.
- ❖ Exclusive breastfeeding is strongly advocated and pushed on you in the hospital however, the nursing staff are not able to provide you with adequate assistance for it and poor supports available on discharge. There is a need for more hospital and community based lactation consultants.
- ❖ HSE has a zealous campaign encouraging breast-feeding but very little information on the reality. I experienced a lot of issues with feeding and received inconsistent advice on the postnatal ward.
- ❖ I feel the breastfeeding supports in the hospital, and once we returned home, were NOT adequate.

### 7) Debriefing services

- ❖ I think all women should be offered a debriefing session to help explain why things happened the way they did during labour and birth. Not fully understanding what happened during my first birth added to the experience of trauma and fear in the weeks before the second birth.
- ❖ Debriefing of mums after as it's a huge experience women go through and this should be acknowledged and given space to sink in with a professional leading it, or a group situation.

- ❖ *For mothers who had traumatic births, no post birth support in place to allow them to sit down once the fog has cleared and go over the birth. I asked lots of questions in the days after the birth but I was on a lot of medication and was completely unable to process.*
- ❖ *In the 2 days I stayed in the hospital after the birth, no one came to debrief the birth with me. I would have liked to talk through the experience, and felt quite alone, especially considering the other women in my ward all had someone talking with them. You asked us if there was time for questions after giving birth, as well as a debrief. Yes, those things happened, but I wonder if there might be a better time to tackle some of this with the new mums. I was completely exhausted after I gave birth and had no clarity of thought to ask anything or to particularly take in what was being said to me. I am still very confused about some aspects of my labour, but it took me a while to even know that. I was too busy staring at my baby to think about it at first!*



**Trinity College Dublin**  
Coláiste na Tríonóide, Baile Átha Cliath  
The University of Dublin

Produced by the Trinity Centre for Maternity Care Research (TCMCR)

School of Nursing & Midwifery,  
Trinity College Dublin,  
The Gas Building,  
24 D'Olier Street,  
Dublin,  
D02 T283.  
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