Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Report on the RQIA Review of Intrapartum Care in Northern Ireland: Belfast Health and Social Care Trust

13 May 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Sam Gardiner
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:
Ms Eliz Bannon)
Mr Brian Barry) Belfast Health and Social Care Trust
Ms Ruth Clarke)
Mr William McKee)

The Chairperson (Mr Wells):

I welcome the officers from the Belfast Health and Social Care Trust, in particular its chief executive, Mr William McKee, who had to amend his busy schedule to be here and whom we all know. I welcome Brian Barry, the acting director of specialist hospital and child health, Eliz Bannon, the co-ordinator of maternity and women's services, and Ruth Clarke, the maternity services manager. You should make a 10-minute presentation, after which I will open the meeting to members' questions.

Mr William McKee (Belfast Health and Social Care Trust):

I thank the Committee for Health, Social Services and Public Safety for the opportunity to reflect on the intrapartum care that is offered to women in Belfast and regionally. I will provide the Committee with some context, list the Regulation and Quality Improvement Authority (RQIA) recommendations for the Belfast Trust and explain how it is addressing them.

More than one quarter of births in Northern Ireland are delivered in the Belfast Trust. In 2008, there were 25,500 births in Northern Ireland, and more than 6,700 of those were delivered in the Belfast Trust area. An increasing number of women give birth over the age of 30.

The Belfast Trust provides maternity services in the maternity unit at the Mater Hospital and at the Royal Jubilee Maternity Service, where, as well as the district services provided in the other nine units, we provide the regional neonatal service and the regional referral centre for high-risk and complicated pregnancies. Northern Ireland is fortunate to have all its specialist paediatric services, including critical care, on the same campus at the Royal Belfast Hospital for Sick Children.

At the start of the RQIA review, no guidelines for childbirth were available in Northern Ireland, and, as the RQIA representatives stated, they used a 2007 document produced by the Royal College of Obstetricians and Gynaecologists (RCOG), 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'. Those guidelines were not adopted in Northern Ireland. Subsequently, in August 2008, Northern Ireland adopted the National Institute for Health and Clinical Excellence (NICE) guidelines, and a circular was issued in October 2008 that was based on lessons learned from major incidents and independent inquiries to give further guidance to trusts. Therefore, the standards against which we were measured were not adopted in Northern Ireland, and, subsequently, guidance was issued in Northern Ireland.

Based on the safer childbirth set of minimum standards issued by the RCOG, the Belfast Trust, like the other trusts, was asked to assess itself and report against 45 criteria across 10 standards, in five levels of achievement and five of corporate development. In short, we had to score ourselves across 55 separate measures. On behalf of the RQIA, the review team visited us and assessed our self-assessment score and agreed with 43 of the 55 scores. Subsequently, the review team assessed us against 31 additional recommendations. Given the regional referral and

high-risk role, particularly for the Royal Jubilee Maternity Service, I will mention just one of the 10 standards, emergencies and transfers, against which we either fully or substantially achieved all eight criteria standards at the top two levels of achievement.

Against the 55 assessments and the 31 additional measures, the RQIA made five recommendations, which I will go through quickly. We sometimes found it difficult to work from the narrative and the score to the recommendation. For example, in the narrative, we were highly commended on clinical audit, but the RQIA asked that we appoint a clinical audit lead to direct multidisciplinary audit. We thought that we were doing it well, but we have now identified a lead and a multidisciplinary programme of audit has been agreed to progress the matter.

The second recommendation concerns staffing levels. As Mr McDevitt pointed out in the previous evidence session, this is the only standard on which we did not achieve the target. No doubt the Committee will wish to return to this issue. The reason is that the number of hours of consultant obstetrician time in a delivery suite is linked, in the RCOG recommendation, to the number of births. We do not meet that standard. It is not in our gift to employ a consultant obstetrician for whom we do not have the money. That is a matter for our funders, the commissioners. We will work with them to try to increase the proportion.

We are also asked to review the future of the smaller of the two obstetric units at the Mater Hospital. In line with RCOG guidelines about smaller units, we have already, in 'New Directions: A Conversation on the Future Delivery of Health and Social Care Services in Belfast', set out the future of obstetric services in the Mater Hospital: consultant-led services should transfer to the new central maternity hospital when it is built, and a midwifery-led unit should remain, which is in line with guidance. We are happy to work with the Health and Social Care Board, but, as you are aware, the Minister of Health, Social Services and Public Safety has decided to undertake a regional review of maternity services that will, no doubt, include the future of the Mater Hospital.

The third recommendation concerns leadership and the on-site presence of statutory supervisors or midwives in the Mater Hospital. We have strengthened our leadership and made considerable progress. We now have a ratio of 1:10 supervisors to supervised midwives, which brings us much closer to the standard of 1:15. The trust has a system in place to ensure 24/7 access to a supervisor of midwives for advice and guidance in line with standards.

It is also recommended that the trust should appoint a labour ward manager in the Mater Hospital. We appointed a senior midwife at band 8a, who is in place and is responsible for the delivery of intrapartum care. She is supported by a team of band 7 midwives with clinical and managerial responsibility, which ensures that both labour wards have a 24/7 presence to manage and lead. That is supported by 24-hour access to an on-call senior midwife manager.

The fourth recommendation concerns training and education and how we should ensure, through clinical support and supervision, that medical staff are fully supported and adequately prepared for the work that is undertaken in the birth setting. The trust was commended on its training programme and continues to work to strike the right balance between service provision and support for educational needs. Through the recent job-planning process, which you, Chairman, referred to in the previous evidence session, we identified specific remits for consultants to undertake the role of educational supervisors and to ensure the development needs of junior medical staff.

The fifth recommendation concerns environment and facilities, particularly in relation to the Royal Jubilee Maternity Service. The building is old and not functionally fit for purpose. We worked hard and undertook a number of refurbishment projects. Most of them concerned safety and were behind the scenes, but, more recently, we were able to use limited capital to improve the environment and to refurbish the wards. We will examine our priorities to see whether we can address the recommendations for the Mater Hospital.

The RQIA review report notes that we continually invite comments from users of our services, and we use an independent and highly respected third party, the Picker Institute, to do that from time to time. We were interested in the comments in the survey of users' views, where we received a very high satisfaction rate. I will select two questions. When women were asked to what extent they or their birthing partner felt that they were treated with respect and dignity, 93% responded either "completely" or "very"; I think that some 75% responded "completely". When women were asked to what extent they had confidence and trust in the staff caring for them, almost 96% responded either "completely" or "very".

I am very proud of the maternity staff in the Belfast Trust, who work to very high standards with limited resources, often under great pressure. We can, however, always strive to do better.

The RQIA review process was helpful because it began with a detailed self-assessment, which was almost completely vindicated by the review team. It did not tell us anything that we did not know, and we have, since before 2008, striven to improve our standards and will continue to do so.

The Chairperson:

Thank you, Mr McKee. Does anyone else in the deputation wish to say anything?

Mr McKee:

I am happy to invite them to say something, but I am holding them in reserve for wicked questions.

The Chairperson:

We accept that the review revealed a very high level of contentment and support for maternity services in the Belfast Trust and throughout the country. That reflects my personal experience as a constituency representative. Although we receive many complaints about A&E, minor injuries and such issues, maternity services generally seem to be doing reasonably well as far as the clients are concerned.

However, there are some storm clouds on the horizon for the Belfast Trust, one of which is the almost certain closure of the maternity unit at Lagan Valley Hospital. Although the hospital is not in the Belfast Trust area, it will inevitably mean a transfer of mothers to the Mater Hospital and the Royal Jubilee Maternity Service. You are obviously aware of that. Are you planning for it? What will the impact be in five years' time if that happens?

Mr McKee:

I will answer first, and I will then ask Eliz to provide another layer of detail.

We expect the closure to happen sooner rather than later, and certainly not in five years' time. It is always difficult to predict the choices that mothers will make. The Royal Jubilee Maternity Service feels rather sensitised about the issue because, over the past decade, the number of women who choose central Belfast as a location to give birth has been consistently underestimated. Although the numbers remain fluid, we are preparing on the basis that perhaps as many as half of all the women who currently choose Lagan Valley Hospital — approximately

800 — will choose the Royal Jubilee Maternity Service. That will put extra pressure on accommodation, but we have plans in place to accommodate the increase.

Ms Eliz Bannon (Belfast Health and Social Care Trust):

You are quite right, Mr Wells. The women who use maternity services are mainly supportive of midwives and the medical staff. Given that childbirth is a whole experience for them, and they are going home with a baby, they work well with us to have as good an experience as they can. Therefore, women do not generally complain much about maternity services, and that is to their credit.

We work with the Health and Social Care Board, the South Eastern Health and Social Care Trust and the Southern Health and Social Care Trust, along with colleagues from the Public Health Agency, the commissioners and the Department, to consider what may happen at Lagan Valley Hospital. We have a clear view that whatever resources are there should follow the women, because, as Mr McKee said, women will make choices about where they will go. We will plan and ensure that we have enough staff and the right environment, information and pathways for women so that their journey does not become more difficult.

At the moment, a substantial number of women come from the Lisburn area to Belfast, partly because people work in Belfast and because of family connections with Belfast. We have a tradition of providing care. We have to ensure that women do not have to travel to Belfast to receive elements of their care, such as antenatal care, which can be delivered in the Lisburn area. The same community midwives who currently look after women in the Lisburn area should still have that relationship with them. We want the reorganisation to be as least disruptive as possible for women.

Ms Ruth Clarke (Belfast Health and Social Care Trust):

The major negotiation at present is about revenue, and that revenue must follow the path that women choose. For women who choose Belfast for their birthing experience, having had antenatal and post-natal care in their local area, the revenue should come forward so that they have a complete, safe and effective package of care.

The Chairperson:

While that storm cloud gathers to the west of the Belfast Trust, there are other problems within

the trust. Most people believe that the building housing the Royal Jubilee Maternity Service is past its sell-by date and a new one is needed urgently. There also some shadows over the Mater Hospital, in that 'Maternity Services: Future of Small Units' has been published and the Mater Hospital must be considered in that context. Given those two factors, can the Belfast Trust meet future needs, even if the Lagan Valley maternity unit does not close? What will happen if we do not get a new women and children's hospital in Belfast? What will the pressures be?

Mr McKee:

We are not contemplating that level of failure, even though the financial outlook and choices made heretofore in public expenditure make it unlikely that the new hospital will be built soon. The best estimate is that the new building will be completed towards the end of this decade. We will continue to use what money we have to refurbish the existing building.

Notwithstanding the fact that the building is not functionally suitable, we demonstrated that we can make it safe through health and safety policies and by refurbishing existing wards and user areas to bring them up to a higher standard. In the absence of a newbuild, we will continue to do that and to do our best. I place greater reliance on the staff than on the building and hope that we continue to attract, train and retain high-quality staff, particularly midwives.

The Chairperson:

The report indicates the shortcomings of the structure of the building. Logically, it should be being replaced as we speak.

Mr McKee:

Of course it should.

Ms Bannon:

You are absolutely right; it is an old building. The delivery suite on the RVH site saved maternity services in Belfast. When it opened in 1969, it was a vision and an inspiration to the planners at the time. The delivery suite, the configuration of the rooms, the allocation of theatres and the size of the suite means that we have been able to continue to provide women with a good environment in which to give birth. We take into account, with no argument, the RQIA's view that the suite could be more homely, because, with its magnolia walls, and so forth, it is certainly not homely. We have made strides, which Ruth, as head of midwifery, can tell you about.

Recently, we obtained some money to refurbish the suite and create four additional labour or home-birth rooms. Given the way in which the building was configured and the linkages between services, we were able to do a really good job to ensure that women coming to the RVH site to have a baby have a good dedicated roomy environment. When they are in labour, they are not sharing the space with anyone else.

Ms R Clarke:

I re-emphasise that we have put much effort into maintaining the fabric of the old building while acknowledging its limitations. It is fair to say that we all aspire to a newbuild. The trust put huge commitment and effort into planning and producing a design template for the newbuild, which has robust and sound principled clinical linkages and would be a wonderful environment for the women of today, who deserve it.

The economic climate has intervened, and we all know where we are. However, we resent the fact that it is 10 years this month since the closure of the Jubilee Maternity Hospital, and we still do not have that newbuild. You are aware of the circumstances as much as we are. It is not a lack of will on the part of the trust or of women.

We hope that, somewhere down the line, the new facility will become a reality. Our peer services around the Province have had regular improvements to their physical environments. For example, Craigavon Area Hospital has been rebuilt twice in the past 30 years. Therefore, it is difficult for the trust to reassure women constantly that it is doing all that it can to improve the environment in which women have their babies. I do not want the focus to become, as Mr McKee said, the fabric of the walls. The quality of the service is dependent on the people.

Mrs O'Neill:

I am happy to discuss maternity services with you, especially given the negative press that the Belfast Trust received about discharging women six hours after they had given birth.

In the absence of a maternity strategy, what has the trust done to develop the consultant midwife role? Is that a role that you value?

Ms R Clarke:

We value that role and strongly support its being put in place. However, we have not been in a position to divert moneys from our fund for the establishment of midwives to create that post. Had we had some further outside investment or resource, we could have made that post a reality much more quickly. It is only when we achieve a level of staffing that allows a little bit of ease and comfort that we can divert some of our existing budget into creating that post. However, our priority has been to ensure that there are enough band 5 and band 6 midwives' posts to provide clinical care at the bedside, whether that is one-to-one care in labour, which we achieve some 98% of the time, or whether it is post-natal care in the hospital or in the community.

Mrs O'Neill:

The RQIA recommended that a future model for the provision of maternity services at the Mater Hospital could be based on 'Maternity Services: Future of Small Units'. What is in that publication, and what is the potential?

Mr McKee:

The RCOG publication places smaller units into two categories: those that are geographically remote or isolated from a larger central unit; and those that are geographically close. Therefore, the maternity unit at the Mater Hospital falls into the second category. It states that there are broadly three options: to close the unit; to have a midwifery-led service only; or to review the risk level further so that, prospectively, even less risky births are contemplated only in the smaller unit.

Ms Bannon:

The RCOG considers a number of suggestions about medical models or at midwifery-led care. As Mr McKee said, that is in keeping with the strategy that the trust put out to the public three years ago. I repeat: it is about the levels of care rather than the building. However, the Mater Hospital currently operates a very good service. Women are seen antenatally, and decisions are made about risks such as diabetes or twin pregnancy. Those women are asked whether they will attend to give birth on the RVH site. Consultants in the Mater Hospital cross cover to the RVH site, so it is not about placing women somewhere entirely different. That is one way in which small units operate across Northern Ireland. Lagan Valley Hospital, for example, has an excellent risk assessment process so that it reduces the risk to women, which is what everybody wants.

The Chairperson:

I want to give Conall time to speak, because the Royal Jubilee Maternity Service is located in his South Belfast constituency.

Mr McDevitt:

Mr McKee, I want to pick up on a point from your opening remarks that there is contention or disagreement about the specific criteria to measure staffing standards. If I heard you correctly, you suggested that the RQIA was over-reliant on what you described as professional bodies' standards. Will you clarify that specific point, because if we are talking about non-achievement, I want to know what standard is not being achieved?

Mr McKee:

Out of the 55 measures on which we were assessed, we were deemed to have failed to achieve on one standard, in which the RCOG links the number of births to the number of dedicated obstetrician hours in the delivery suite. A highly respected colleague in the RQIA fell short of saying that it was an aspirational target on the part of the RCOG.

Mr McDevitt:

That is standard 4.3.

Mr McKee:

Yes, it is. We achieve a number of dedicated hours that falls short of the RCOG target, which was nearly called "aspirational". My midwifery and obstetrician colleagues and I would like more dedicated obstetrician time in the delivery suite in the Royal Jubilee Maternity Service. Yet again, it is a matter of funding. I am not permitted to spend money for which I do not have a budget, and the Health and Social Care Board is also anxious about that.

Mr McDevitt:

I accept that, and we all support your bids for greater funding, but you also failed to achieve standard 4.6. Is that explained by the same argument? You did not fail to meet only one standard; you failed to meet, on my count, four and possibly more standards than that.

Mr McKee:

I seem to recall that the RQIA said that, even if the shortcoming came from the smaller of the two

units, the entire trust was failed. As the report lists in some detail, we struggle to provide the required level of anaesthetic cover in the Mater Hospital. Nevertheless, we do quite well, but we fail to meet the RCOG standard.

Mr McDevitt:

How should the RQIA model the standards if not by the RCOG standard? What would be a better way to monitor standards?

Mr McKee:

We are happy with the current position. I was simply pointing out that, at the time of the review, there were no Northern Ireland standards and that the RCOG standards were used. Soon after that, later in 2008, we got standards and recommendations.

Ms Bannon:

I am not aware of any hospital maternity service across the UK that achieves all the RCOG standards. However, we all accept that those standards are based on a well-regarded and well-respected knowledge base. It is the point of the journey that one would wish to reach, but it will involve making choices with limited resources. That reflects the report's comments about what could be sustained in the Mater Hospital. If, for example, the commissioner gave £1 million to William, that may not be the best way to spend money to get the best outcomes for all women.

Mr McDevitt:

What is your honest opinion on the future of maternity services in Belfast? How many centres should there be?

Mr McKee:

We set out our vision in 'New Directions' that there should be one consultant-led obstetric service in the Royal Jubilee Maternity Service, ideally in a new building in a new central maternity hospital, and that there should be a midwifery-led service in the Mater Hospital. In that way, we could offer the widest choice to women. At the root of it all is the offer of informed choice to women. That must always be our North Star.

Mr McDevitt:

Whether your strategy or anyone else's is adopted, midwives will play a more central role. How

many midwives work in the Belfast Trust?

Ms Bannon:

Before I answer that: midwives have always played a central role.

Mr McDevitt:

I said that they will provide a more central role.

Ms Bannon:

My standard statement is that all women require midwives, and some also require a doctor.

Mr McDevitt:

How many midwives work in the trust?

Ms Bannon:

There is a funded establishment of 201, almost 202, midwives. In the Mater Hospital, there are 30·87 whole-time-equivalent posts.

Mr McDevitt:

Regionally, the report was concerned at the average age of midwives and found that it is an ageing profession. What is the average age of a midwife in the Belfast Trust area?

Ms Bannon:

I cannot give you an average age, but a large proportion of midwives are aged 50 and over.

Mr McDevitt:

Do you know how many, or what proportion, are over 50 years of age?

Ms Bannon:

Twenty-six per cent are over 50 years of age. I am sad enough to have tried to work that out last night. Ruth and I are in the under-50 age group.

Ms R Clarke:

You are only 29.

Ms Bannon:

We are 29 and 37.

Ms R Clarke:

We have been raising that issue with the commissioners and the Department, along with other organisations such as the Royal College of Midwives, for some time. That future pressure has been recognised, and, later today, the Department will probably say that the number of training places has been increased for student midwives, both via direct entry and the nurse qualification route.

Mr McKee:

Mr McDevitt, we benefit from the fact that the Royal Jubilee Maternity Service, even with its poor accommodation, is seen as the first job choice for midwives who come out of training. Although we have the same broad feature of reliance on midwives who are over 50 years of age, that is leavened by the fact that younger, more recently trained midwives choose the Royal Jubilee Maternity Service as their first job. If I recall correctly, that is reflected in there being 40 applicants for 10 posts.

Mr McDevitt:

To be clear: is the issue with consultant midwives a question of funding and institutional relationship rather than one of policy?

Ms R Clarke:

That is right. We all support that role, and some individuals are almost performing that function without the salary or the recognition.

Mr Gardiner:

I pay tribute to Ruth, because the Committee visited the Royal Jubilee Maternity Service, and the standard of care that was given to sick and premature children was unbelievable. Ruth conducted us on that tour, and I was very impressed. I agree with you that there is definitely a need for a new building; it should be the top priority.

Do you have a record of the number of stillbirths or of any problems that were encountered

when, perhaps, an anaesthetist has not got to a patient in time? What are you doing to ensure that you have an anaesthetist? Do you have a record of the number of complaints that you receive? Although you said that you do not receive many complaints, we can build on them to try to improve standards.

Ms R Clarke:

I do not have specific statistics for incidents in which a stillbirth could be attributed to a failure of anaesthetic cover, but I have the overall figure for stillbirths in our service, which was 28 in 2009. We have good outcomes in relation to stillbirths, perinatal and neonatal deaths across Northern Ireland. In a UK context, our performance is the best across the four countries. The Royal Jubilee Maternity Service has robust anaesthetic cover; at least one person is always there within hours, during the day and out of hours. During the day, there are three people: two consultant anaesthetists and one in training.

In the small maternity unit, in line with all small units, anaesthetic cover is provided to the entire service — obstetrics, medicine, surgery, and so forth. A robust anaesthetic team covers all services. We meet the standards for a small service, in that an anaesthetist is available within the required 30 minutes of the standard. That is the simplest way to answer that question.

You already discussed with the RQIA the scenario of an anaesthetist team being involved with one emergency when another emergency arises in obstetrics. Your assessment is quite right: there is a limited time frame in which to respond to that second emergency to achieve an optimum outcome. It is true that, at times, we do not meet that outcome, in line with all small services across the UK.

Mr Gardiner:

When you do not meet the standard, does it ever lead to the death of a child?

Ms R Clarke:

The potential is there.

Ms Bannon:

A baby may not die; it depends on the condition of the baby and what sort of damage the baby may have sustained due to lack of oxygen or anoxia. Parents may be left with a baby with many

problems, but it is very rare for that to be attributable to a solely anaesthetic cause, because it may be that the baby is premature or very small or that the mother is bleeding. There are many variables.

Ms R Clarke:

It is difficult to know how much pressure that baby had been under and for how long before delivery or the complication becoming overt.

Mr McKee:

Perhaps I can answer that in a different way. The key issue is whether a close track is kept of new misses and whether they are reviewed. A good organisation is honest and open about reporting near misses because, by learning lessons from near misses, hits are avoided. We have well-developed risk management and near-miss reporting arrangements, so when something goes wrong or almost goes wrong, multidisciplinary staff ask what went wrong. That is the key issue.

Mr Gardiner:

I hope that that does not happen again.

Mr McKee:

That is what we strive towards.

Ms R Clarke:

Those were the very considerations that the trust took into account when it published 'New Directions'. The trust also took those considerations into account when deciding that the small unit could function well as a midwifery-led unit, with high-risk business managed in the major obstetrics unit. The major unit has highly skilled consultants, is highly resourced and has the high levels of required expertise. That means that resources will not be divided across the two bases.

Ms Bannon:

That will mitigate the risk, but it will not eradicate it. Childbirth, by its very nature, is an unpredictable business. A pregnant woman can be completely normal and healthy in every respect, with a baby growing who appears to be normal and healthy, and something can go wrong. In maternity services, we have, and have always had, a system of reviewing unexplained stillbirths. A number of babies are born dead each year, and we never fully understand what has

happened. As Ruth said, we had 28 stillbirths last year from 6,500 births.

Ms R Clarke:

Some of those were referrals, because we are the referral centre.

The Chairperson:

Have you ever urgently needed an anaesthetist and frantically tried to find one? What is the longest time that you have had to wait for an anaesthetist? Have there been situations in which you have not been able to get an anaesthetist at all?

Ms Bannon:

In our experience, and between us we have considerable experience —

Mr McKee:

Even though they are both under 35. *[Laughter.]*

Ms Bannon:

The longest that either of us can remember waiting is an hour. In that instance, the baby survived but had cerebral palsy. We do not know whether the wait for an anaesthetist was the sole reason for the baby having cerebral palsy; there may have been other factors. We never have to wait for an anaesthetist on the RVH site; there is one in the labour ward 24/7.

The Chairperson:

Interestingly, the South Eastern Trust is the only trust that met its target. One would expect the Belfast Trust to meet its target.

Ms Bannon:

If Lagan Valley Hospital had been included in the South Eastern Trust's results, it would have received the same result as the Belfast Trust. On the RVH site, there is an anaesthetist 24/7, the ward is fully staffed with senior personnel, and there is excellent support and links to the main hospital. We have had very ill women, and colleagues come from the acute side of the hospital to give additional support. The situation at the RVH works well. The Mater Hospital is a small district general hospital, so it will not have the same provision.

Approximately three women a month need to go to theatre out of hours. A team of consultant anaesthetists could not be employed to accommodate that in the maternity unit at the Mater Hospital.

The Chairperson:

I understand that. That means that the future for small maternity units becomes less and less viable. I do not agree with what is happening, but I can see the logic of what you are saying. The trend seems to be inexorable.

What funding bids have you submitted to the Health and Social Care Board for improved maternity services? You highlighted a series of issues, so the next logical step is to bang on John Compton's door and tell him that you want money to address them.

Mr McKee:

I will let Eliz answer that, because I know from my more informal discussions with her that that is a constant refrain.

Ms Bannon:

Every year, we meet the commissioners to discuss funding gaps. Based on the complexity of our work in 2009-2010, we will look for an additional £2 million, a substantial proportion of which will go towards increasing obstetric levels and for a labour ward and neonatal cover. In the Belfast Trust, we provide 24/7 access to neonatal services for the Mater Hospital, which means that someone with the right level of skills, knowledge and expertise is always there.

The Chairperson:

Is that your only bid?

Ms Bannon:

That is the only bid, but if you would like to give me direction on another one, I would be more than happy to —

The Chairperson:

I thought that you would have had a shopping list.

Mr McKee:

Two million pounds will buy quite a lot.

Ms Bannon:

Two million pounds will buy us midwives, support staff, goods and services, some psychology, clinical and clerical support, and other key support and domestic services.

Mr McKee:

In the three years from 1 April 2008 until the end of this financial year, 31 March 2011, real, above-inflation growth in England has amounted to more than 11%. In Northern Ireland, growth has been barely 3%, which will be almost entirely wiped out by the Executive's most recent Budget decisions. Consequently, the challenge for the Health and Social Care Board and our funders is to deal with a rising birth rate when there is no real growth in funding across health and social care.

Ms Bannon:

In the past few years, the commissioners tried to give us additional money to allow us, for example, to pay backfill, employ additional midwives and meet bank midwifery and medical costs. They worked with us to try to fill the gap. However, they must work within the available purse.

Mrs McGill:

Given all the pressures, the disappointment of the newbuild not being in place and the report commending the fact that mothers are content — in some cases, very content — with the care that they receive, how difficult is it to maintain high staff morale? Is that a challenge for you? I am not sure whether it is possible to answer this question, or whether I should even ask it, but, given that mothers are so content with the care that they receive, that must put pressure on staff. How is that pressure managed? Again, the staff must be commended.

Ms R Clarke:

You are quite right; the situation is extremely difficult, and staff morale is not as high as it might be. Staff feel that the service is extremely busy, which it is. The Northern Ireland birth rate has increased by some 11%, so the service is busy. Staff have personal standards and expectations about the level of care that they want to deliver, but they struggle to come to terms with the

pressures and the changes that are taking place. They struggle to see how care will be delivered in the future, while protecting the key principle of one-to-one care in labour. Undoubtedly, staff are finding that difficult.

How can we manage that change? What can we do about it? Recently, through issues that were raised by staff and the intervention of their professional organisation, it was highlighted that, although we thought that our communication channels were extremely robust, there is a blockage, and some information is not getting down to the grass roots. As individuals, we have a responsibility to keep ourselves informed, so there is a two-way responsibility. However, we have a renewed energy about how we ensure that all communication goes down to the grass roots.

We are re-profiling our maternity service committee structure, and we have had meetings about it. We hope that that will improve, and if people fully understand the reasons behind the actions, that may help. People also need to be reassured that they are working within a safe policy framework so that individual registrants and practitioners do not feel vulnerable and realise that it is OK for a woman to go home early from a maternity unit, provided she does not have an absence of care. Post-natal care will still be provided, but it might be delivered in a different way with the benefit of one-to-one care at home.

If a woman stays in a maternity unit for two days, that is no guarantee that she will receive the necessary interaction with a midwife. However, if a woman is at home and a midwife visits her each day, she will get one-to-one attention. She will be in her own comfortable environment, have her family round her, have the food that she likes and be able to smoke as much as she likes, and she will have her flowers and her balloons.

The Chairperson:

I hope that that is not the policy.

Ms R Clarke:

Absolutely not. However, we constantly struggle with the health message about women smoking and the public image of women standing outside our maternity unit smoking. Women are in control of their own destiny when they are at home, and it gives them control in another way in that the professional is a guest in their home. One-to-one care at home is a partnership.

Ms Bannon:

The Minister's announcement of a maternity review for Northern Ireland encouraged many staff across the multidisciplinary teams. There is a view that hard decisions may be made, but maternity services resources can be reallocated. For example, if Lagan Valley Hospital's obstetric service were to close, the obstetric presence on another site can be increased, because, as Mr Wells rightly said, the medical teams would have to move. Therefore, staff feel that this is a time of change and things will happen that will improve care. Therefore, they were glad to hear the Minister's announcement. It gave them some consolation.

Mrs McGill:

Thank you for your very full answers.

Mr McDevitt:

I want to come back to a point that Mr McKee raised about best practice in the use of information and the collation of information. In the overview report, standard 1.7 states:

"Information in NIMATS is quality assured but provides limited information on interventions and clinical outcomes."

I would like to hear your response to that.

What investment have you made in the Northern Ireland maternity services information system (NIMATS) to date? The RQIA was unable to answer that question. When did NIMATS come into operation?

Mr McKee:

I thought that it came into operation about 15 years ago, but Eliz has corrected me. She must have been very young at the time, because it was in the late 1980s. It was developed as best practice in the Royal Maternity Hospital and was then rolled out across Northern Ireland. Major ICT schemes in Northern Ireland are reserved to the Department of Health, Social Services and Public Safety (DHSSPS) and its advisory bodies under the directorate of information systems (DIS). Trusts are discouraged from going forward with individual ICT schemes and, rightly, are expected to have regional systems.

We would be the first to say that it is a challenge to wring good information about outcomes from NIMATS. Nevertheless, we can do much with that information, and it underpins much of the standard setting, assurance of safety and future policy. Although NIMATS is a grand old

lady, we still find it helpful and better than the alternative, which would be to have nothing. However, we all agree that it would be much better to have a modern ICT system. ICT development is increasing exponentially, so with every year that passes in which we do not replace NIMATS, it becomes creakier.

Mr McDevitt:

I accept that NIMATS is not your system only. However, the Belfast Trust invested in it. How much has the trust invested in the system over the years?

Ms R Clarke:

Our investment is in one member of staff who is dedicated to managing the system, to the ongoing training of staff in using the system and to quality assurance of the information and statistics that are in the system. That member of staff cross-checks everything, and, because of her input, I can stand over my NIMATS statistics 100%. Other trusts did not have that level of NIMATS, and although the failures that are mentioned in the report are not specific to my trust, there is a weakness in obtaining the regional picture because some maternity units are not linked in or signed up to NIMATS. However, for the trusts that invested in NIMATS, the quality of information is excellent. We can interrogate the information to monitor birth activity, types of activity and the peaks and troughs of any activity. We can identify where we can change practice to smooth out problems. When the entire region is using NIMATS, it will be really beneficial.

The system could be more user-friendly. It is not yet Web-based but uses the old green screen system, with which some of you may be familiar. It is clumsy and time-consuming. DIS has been asked to update the system, but I am not sure where it is in that process. However, I have no doubt that the Department could tell you.

Mr McKee:

Investment in ITC for each employee in the health sector across the United Kingdom is the lowest of all the sectors. For example, it is lower than in the construction and financial services sectors. Across the United Kingdom, Northern Ireland's investment for each employee is the lowest of all the health systems. In Northern Ireland, our investment in ICT in health and social care is the lowest of a very low investment by sector.

Mr McDevitt:

My question was trying to elicit what notional part of your budget has been allocated to NIMATS since the system was introduced. You have a budget line against NIMATS: what is it?

Ms R Clarke:

It is the salary of a band 5 employee. I am sorry; it is actually more than that because our dedicated staff member spends time training staff. Therefore, it is the staff time cost for the time that she trains them.

Mr McKee:

I am happy to write to the Committee with information on ICT investment in the Belfast Trust.

Mr McDevitt:

That would be helpful.

The Chairperson:

I have one final question that concerns the Mater Hospital. The RQIA report states that you must consider the future of smaller maternity units. I assume, as you have had the report for some time, that you have done that.

Mr McKee:

In 'New Directions', we set out our 10-year vision for the development of all services across the Belfast Trust. We want consultant obstetric services in the Mater Hospital to be transferred to the new central maternity hospital, with the midwifery service remaining in the Mater, which is entirely in line with RCOG recommendations. We have already set out our policy view of the future for the Mater Hospital.

The Chairperson:

Is that predicated on the new women and children's hospital, or would that happen anyway?

Mr McKee:

At the time that we set out that policy and consulted widely, we were more optimistic that there would be a new central maternity hospital.

The Chairperson:

I am looking at the figures on midwives — I shudder to think what three quarters of a midwife looks like — and, in whole-time equivalents, there is a huge disparity between the volume and size of the two units. The Royal Jubilee Maternity Service is on a different planet to the Mater Hospital in relation to throughput.

Ms R Clarke:

If the figures are calculated down to the number of midwives per births, they are on par.

The Chairperson:

However, the overall numbers are much smaller in the Mater Hospital.

Ms Bannon:

On the Mater site, there is the maternity in-patient ward, which also has antenatal services. The delivery suite is on the floor below. The staffing levels are worked out on a pro rata basis, compared with covering four wards and a 19-bed delivery suite on the RVH site. The volumes of staff are correct in the Mater Hospital, but medical cover is a difficult challenge. There was a discussion with the RQIA. With the 35 hours' prospective cover at the Mater Hospital, we ensure that the consultant obstetrician is in the delivery suite. The consultant's office, which was discussed in the previous evidence session, is one flight of stairs away, so, in our view, it is not a huge distance away. Medical staffing is our biggest challenge in the Mater Hospital. However, it is not within our gift as a trust to make a decision about the future. That will have to be part of the maternity strategy.

The Chairperson:

Mr Barry must be feeling left out in the cold; he has not had a chance to say anything. I am sure that you are feeling quite annoyed, or are you happy enough?

Mr Brian Barry (Belfast Health and Social Care Trust):

I should explain that there are two rules that I always adhere to. Like some of your professional colleagues, particularly across the water, who are adapting to new roles and briefs this morning, I have been in my current role only for a short time, so I am grateful for this evidence session and to the RQIA for a rapid learning curve on all the issues that I face. Also, when the chief executive is present, one normally simply defers. *[Laughter.]*

The Chairperson:

He is a chief executive who seems to have been around since at least the Boer War. As long as I have been involved in politics, he has been a senior official in the medical field.

On a more serious level, I have a final question for Mr McKee. What control do you have over consultants? If you perceive a shortfall in consultant cover in maternity services, in the Mater Hospital or the Royal Jubilee Maternity Service, do you have the right to tell consultants that they will go where they are needed, or do you have to request on bended knee that they go?

Mr McKee:

There are so many ways in which I could answer that question. By and large, consultants are appointed to a detailed job specification based not only on their general specialty but their sub-specialty skills. There are very few general obstetricians any more and even fewer obstetricians and gynaecologists; in fact, we do not really have them any more. One is not an obstetrician but an obstetrician with a special interest in another medical area, and one's job description would normally reflect that. The programmed activities — the half-days that make up a consultant's week — usually reflect that. It is not as straightforward as saying that we are short of consultants in one area so that is where they must work.

In the Belfast Trust, we are proud of the fact that we have a high level of engagement with all senior clinical staff, not only doctors but midwives, and that we have consultants in positions of leadership and management. Although we might be separate tribes within health and social care, we are part of one nation, usually with one vision of how we want services to develop.

Employers have a clunky mechanism through which to review consultants' job plans — their diaries — each week or through the year. However, that is a new intervention, and consultant representatives find it intrusive. We use that mechanism, but we prefer to sit down and talk through the issues that need to be addressed.

In recent months, as part of a programme of engagement, my medical director and I met almost a dozen clinical teams. We met a team of consultant obstetricians and a team of gynaecologists. Eliz and Ruth were present at those meetings, as were other senior staff from different professions. Those staff want proper resourcing to the level of their English colleagues.

They look enviously at similarly sized units doing similar jobs that are better resourced and where, for example, the number of consultants in the delivery suite meets RCOG requirements. We have to say to those members of staff that that money is unlikely to be available.

I have a mantra: please do not take on the responsibility for deciding how much money should be spent on health and social care. That is an issue for politicians in our devolved Administration, and I tell consultants that their responsibility is to make the best use of the money that they have. I tell them to liberate themselves of the problem of needing more money. Conventionally, the discussion leads to consultants saying that resources are being spread too thinly across Northern Ireland in maintaining 10 consultant-delivered obstetric services. They want rationalisation, choices for mothers across Northern Ireland and a smaller number of bigger teams of obstetricians.

The discussion then turns to the deployment of resources and whether consultants' duties can be rejigged at the margins. That would involve them undertaking tasks that are of less benefit and, perhaps, reapplying some of their time throughout the week to strengthen the services that are most at risk. Consultants and midwives are receptive to that. Therefore, I prefer a dialogue approach, through which we share the same vision for what we wish to do and through which we engage to try to sort out problems. We have the rather clunky mechanism of the consultant job plan and the annual review of that.

The Chairperson:

If Ms Bannon were to require an obstetrician from the Mater Hospital to go to another site and if she were to perceive that an obstetrician was available, does she have the power to tell that obstetrician, Mr Smith or Mrs Jones, that they shall go there? Do you have to discuss, conduct dialogue and plead with the person, or can you crack the whip and make the person go to where the clinical need is required?

Mr McKee:

I have been around since the Boer War, Jim, because cracking the whip would not get me very far.

Ms Bannon:

I have no idea of the experience of colleagues who may appear as witnesses, but, in our service, if

an obstetrician is required to go from one area to another to help, they generally do so. Team working is important and not only do obstetricians do that within trusts but, on occasions, they go outside their own trust to help another service — for example, Lagan Valley Hospital. In our service, it has never been necessary to crack a whip. If I were to phone a colleague to say that help was needed somewhere, he or she would go. I am sure that employment law does not allow me to send a consultant and his or her family to live at Altnagelvin Area Hospital for six weeks.

The Chairperson:

I do not want to be parochial about the issue, but if someone were asked to drive 24 miles down the road from Belfast to Downpatrick, the answer would be an emphatic no. We are told that we cannot get around that issue, because Downpatrick is too far away for a consultant from Belfast to travel.

Mr McKee:

There are several issues, Jim. There is a difference between your example and asking a consultant to go to Lagan Valley Hospital to sort out a problem on a certain afternoon. The trusts are separate employers. Consultants apply for a job in the Belfast Trust or the South Eastern Trust based in Downpatrick. Consultants have the same employment rights as the rest of us, and we need to be guarded about that.

One message in the RQIA report is that, because there is a risk element to intrapartum care, in order to deal with every eventuality, particularly in smaller units, staffing needs would exceed any reasonable expectation of funding. More importantly, staff would be there for such a rare, serious event that they would be unable to maintain their skills and standards between those rare events.

The issue is not really about shortage of staff, although Northern Ireland will, undoubtedly, have a shortage of intermediate trainee posts for doctors. Today's headlines about the Northern Health and Social Care Trust concern the difficulty of recruiting enough intermediate grade doctors, particularly to comply with a European working time directive that people should not work for 48 continuous hours. That is a problem. In addition, we cannot staff to these rightly high and rising standards to deal with rare emergencies, which are serious events, in all 10 obstetric units in Northern Ireland. It is not about moving around the existing number of consultants. If we were to have more consultants, in many cases they would wait for long periods

for a rare event and not maintain their skills. That is not simply about resources; it is about how to use valuable staff.

The Chairperson:

Thank you very much for your helpful contribution. As you know, representatives from the Southern Health and Social Care Trust are witnesses this afternoon.