Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Report of the RQIA Review of Intrapartum Care in Northern Ireland: Department for Health, Social Services and Public Safety

13 May 2010

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Tom Buchanan
Dr Kieran Deeny
Mr Sam Gardiner
Mr Conall McDevitt
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:
Ms Denise Boulter)
Mr David Galloway)
Ms Mary Hinds) Department for Health, Social Services and Public Safety
Dr Fiona Kennedy)
Dr Miriam McCarthy)

The Chairperson (Mr Wells):

Welcome, folks. Many of you are no strangers to the Committee. Dr Miriam McCarthy, deputy Secretary to the Department has been before us many times. She is accompanied by Mr David Galloway, director of secondary care; Ms Denise Boulter, nursing officer; Ms Mary Hinds, from the Public Health Agency, who has appeared before us previously; and Dr Fiona Kennedy. You

have all had much experience of how the Committee operates. I suggest that you present for 10 minutes, after which I will throw open the discussion for questions.

Dr Miriam McCarthy (Department of Health, Social Services and Public Safety): I am aware that the Committee took evidence on this issue this morning. If it is acceptable to you, we will keep our introductory comments brief. I will cover general issues, David Galloway will pick up on specific themes from the RQIA report, and Denise Boulter will address general issues on the midwifery aspects of the report.

First, I will address some general points about maternity services. The population of Northern Ireland is 1·8 million, and the annual birth rate is approximately 25,000. In 2008, there were 25,600 births, and, in 2009, that figure dropped slightly to 25,000. There are 11 maternity units across Northern Ireland. The vast majority of women have their babies in a maternity unit, and only a small number opt for home delivery. The largest unit is the Royal Jubilee Maternity Services, which has 5,500 births per annum. The Craigavon Area Hospital, Ulster Hospital and Altnagelvin Area Hospital have obstetric units, with associated midwifery-led units on the same site. The Antrim Area Hospital, Daisy Hill Hospital, Causeway Hospital and Mater Hospitals also have maternity units.

Recently, the Minister announced that a midwifery-led unit would be established at Lagan Valley Hospital in the foreseeable future. In March 2010, a new midwifery-led unit opened in the Downe Hospital and has managed a small number of deliveries already.

The key message about maternity services in Northern Ireland is that we are fortunate, and it is a tribute to those services that we have high levels of safety and quality information. Mortality figures are a crude measure, but perinatal mortality, which measures the numbers of babies who are stillborn or die in the first week of life, is low compared with other parts of the UK. Perinatal and neonatal mortality are low. Neonatal mortality refers to the numbers of babies who die in the first month of life. The facts and figures on the quality of the service are, therefore, extremely favourable.

Similarly, maternal mortality is, nowadays, a rarity, which is a sign of much safer care during the antenatal period, delivery and after delivery. That is true of the Western World. We are part of a UK-wide system that scrutinises every maternal death and tries to learn lessons on a UK

basis. Annually, Northern Ireland still experiences a small number of maternal deaths, as do other parts of the UK.

As to the policy context for maternity services, we look back to the Developing Better Services programme of 2002, which set out the profile and configuration of consultant-led units. That was prefaced by the need to ensure that every woman has access to consultant-led maternity services within one hour.

Since 2002, many developments have taken place. In particular, there has been a significant expansion in midwifery-led care and of midwifery-led units, most of which are run alongside consultant-led units. As we constantly seek to improve facilities across Northern Ireland, there have been many capital developments. Investment was made in Craigavon Area Hospital and Daisy Hill Hospital, and maintenance work was carried out at the Royal Jubilee Maternity Service in Belfast. Another factor in the quality of care is that Northern Ireland has a higher ratio of midwives to women during delivery than other parts of the UK. Denise will say a few words about that shortly.

A further aspect of the policy development is the Minister's recent announcement, on 2 April 2010, of a regional review of maternity services. That review group has now been established, and its first meeting is scheduled to take place next week. We are fortunate that the multidisciplinary leads in the review are Dr Paul Fogarty, who is the chair of the Northern Ireland branch of the Royal College of Obstetricians and Gynaecologists and Cathy Warwick, who holds a senior position in the Royal College of Midwifes and will travel over from England to attend meetings. We have drawn from the significant number of stakeholders across professional groups, hospital management, primary care and maternity liaison committees to make up the group. Its work should be completed by the end of the summer or early autumn. It will embark upon considerable participation and discussion with a wider range of stakeholders, including service users. I will be happy to respond to more detailed questions on that.

I turn to my colleague Mr Galloway, who will briefly cover some of the themes in the RQIA report.

Mr David Galloway (Department of Health, Social Services and Public Safety):
The first issues that I want to identify relate to the overall comments made by the RQIA about

maternity services. We should take some reassurance from the fact that the review team commended the dedication of staff who work in each of our maternity units for their efforts to provide safe, high quality services to the people of Northern Ireland. The review team specifically commended the approaches being taken by trusts to enhance the safety and quality of maternity services.

This morning, the RQIA, and perhaps the Belfast Trust, may have mentioned to the Committee the satisfaction ratings that were returned following the survey of mothers. The survey shows that users of the service have a high regard for the care and attention that they receive in maternity units, and that is an important indicator of the quality of service. We are also somewhat reassured that the review found some excellent examples of communication with service users in the development and improvement of services. The role of maternity services liaison committees across Northern Ireland was also noted as being of value.

In particular areas of the report, the RQIA's findings suggest room for further improvement. During this morning's evidence sessions, there was some discussion about the nature of the standard of staffing levels, the availability of obstetricians, anaesthetists and others in the labour ward, and what the standard was intended to reflect. The standards provide a good benchmark for the development of maternity services in Northern Ireland. They are, to an extent, a road map of where one would want services to be at a point in the future. That is reflected in some of the recommendations on the number of hours of cover provided by obstetricians or anaesthetists in various units.

The review team found that trusts deliver one-to-one midwifery care for women in labour. Across Northern Ireland, the ratio of midwives to births is 1:26. The national ratio is1:28, and, in some parts of the UK, as high as 1:37. In Northern Ireland, therefore, a substantial number of midwives provide services to mothers.

Also this morning, there was some discussion on the availability of anaesthetic cover out of hours and during the day. Members may want to reflect on an important standard in the report. Standard 7.4, which is a required standard, records the trusts' ability to respond to an emergency Caesarean section. The review team found that each trust was able to respond within the time set by the standard. That finding reflects the fact that the trusts' systems and risk management processes adequately ensure that anaesthetic support is available when required.

The report also examined the information systems that are available to maternity units and the availability of information from audit. The Health and Social Care Safety Forum has been working with each of the five trusts on the development of a maternity dashboard of indicators, which will provide a set of standardised information for audit purposes. The Northern Ireland maternity information system (NIMATS), the trusts and the safety forum are working together to ensure that, in future, people can access the information that they need to be assured of the quality of the service.

The Chairperson:

I am sure that you caught the drift of some of this morning's questions to the RQIA and the Belfast Trust. I hope that not too much will come as a surprise to you. What is the status of the maternity strategy, and when will it be delivered?

Dr M McCarthy:

The strategy was announced in April 2010, and the first meeting will be held next Tuesday or Wednesday. We expect that work to be carried out over a number of months, and we hope that it will be completed in September or October 2010. Following the normal format, we expect that it will, subject to the Minister's approval, go out for full consultation. We are trying to work as quickly as possible to reach early completion.

The Chairperson:

I think that Sue wants to come in on that point.

Ms S Ramsey:

I do, because I wrote down what the Chairperson said, and it gives rise to a valid point. The strategy will also have to be subject to a period of consultation that will last for a minimum of 12 weeks. It strikes me that the Department does not consider it to be urgent, because it could be at least another two years before a strategy is in place. Each of the trust already has a strategy. Why can those not be combined into a regional strategy that takes on board clinical standards? Based on the RQIA report, I am not convinced that the Department takes the issue seriously. It is as though the Department is putting the report on the long finger. That is not a criticism of the people who are involved in maternity services, because they do excellent work with limited resources.

Dr M McCarthy:

You make a valid point, but there may be two separate issues to consider. First, a response may need to be taken forward quickly in light of specific RQIA recommendations, and that will happen. Secondly, there is the more strategic issue of a wider regional policy to cover much more than the RQIA report. As was discussed briefly this morning, the RQIA report focused on intrapartum care. However, we are acutely aware that other aspects of maternity services require examination, which we will carry out over the next couple of months as part of the regional review. The review will cover antenatal care, post-natal care and significant quality and safety issues. Fundamental to all our services is the requirement to maintain, sustain and improve quality and safety.

The regional review will also cover the workforce issues that are identified in its terms of reference as key areas. We envisage that the review will follow a woman's journey and assess the stages of her care throughout maternity services. Some elements of the regional review will be more long term and strategic, but that does not mean that the RQIA recommendations that need to be developed in the short term will not be progressed.

The Chairperson:

I meant to ask at the outset why no representative from the board is here today.

Dr M McCarthy:

Mary Hinds and Dr Fiona Kennedy are here. We are conscious that the Health and Social Care Board and the Public Heath Agency work closely together. We are wearing our commissioning hats today, and I hope that we will be able to respond to any issues that members may raise.

The Chairperson:

Mary and Fiona are most welcome. Ms Hinds is a regular Committee witness and is highly experienced. However, were there some procedural difficulties? Did the board refuse to come along today? Were representatives asked to come? From a commissioning point of view, it is essential that representatives of the Health and Social Care Board be here.

Dr M McCarthy:

There were no procedural issues. In seeking the breadth of expertise for today's meeting, and

given the issues in the report, we thought that a focus on nursing, public health and medical issues would be important. Mary and Dr Kennedy work closely with their partners in the board daily and will, I hope, be able to reflect on and respond to any questions.

The Chairperson:

That leads me to my next question. The most recent guidance on the commissioning of maternity services was produced in 1996, which is some 14 years ago. There have been major changes since then, including an increase in the birth rate, a rise in the complexity of care for women, a rise in the expectation of standards and a fall in the number of maternity units. Are there any plans to establish new commissioning guidance to replace that which is clearly out of date?

Dr M McCarthy:

I will ask Mary to respond on the specific issue of commissioning guidance. The most recent formal review was some years ago. The Developing Better Services programme set out the configuration of maternity services in the context of other acute services.

In recent years, we have endorsed and issued additional guidance to the health and social care sector on the quality of care in maternity services, including the issuing of National Institute for Clinical Excellence (NICE) guidance in 2008. We issued some specific NICE guidance on looking after people who develop or have existing mental health difficulties during and after pregnancy. Over the years, several measures have been implemented to ensure the maintenance of, and improvement in, standards. I will ask Mary Hinds to comment more specifically on the development of the commissioning element.

Ms Mary Hinds (Department of Health, Social Services and Public Safety):

You are right that the specific guidance to commissioners was issued some time ago. However, commissioning has not happened in a vacuum. As Dr McCarthy outlined, numerous pieces of clinical guidance that inform commissioning, including some from NICE, have been issued subsequently. Each of the legacy boards took all that guidance on board.

Alongside that, there has been policy development that included, for example, Developing Better Services. Although a huge of amount of detail was not provided on maternity services, the commissioners were given a sense of the direction in which they could go. In 1996, maternity services were radically different to those that exist now. That is, in part, because of the work of

the commissioners, who made changes, improved choices for women and made services safer and better.

We have done our best to implement the commissioning plans that we inherited from the four legacy boards. We have worked with the services that are under pressure and tried to relieve that pressure in-year where possible. The joint commissioning plan is complex, because the Health and Social Care Board leads the development of the plan and the Public Health Agency provides advice on specialist nursing, midwifery, public health medicine and the allied health professions. We are in the process of finishing that plan, which will, subsequently, go to the Department and the Minister for consideration.

The Chairperson:

Mary mentioned the issue of midwifery-led units, to which the RQIA report also refers. The new Downe Hospital was also mentioned. My experience of that hospital is that the introduction of its midwifery-led unit was delayed considerably because senior midwives could not be attracted to staff it. Some discussion also took place on the possibility of a similar unit being established in Omagh. However, it is not good enough simply to have fantastic facilities, such as those at the new Downe Hospital. Its maternity building is beautiful and is similar to an aircraft hangar or airport, but it is no good having the building without the staff. Are you tackling the issue that junior doctors, consultants and senior midwives cannot be attracted to staff those facilities?

Ms Hinds:

You are absolutely right. In the case of the facility at Downpatrick, it was unfortunate that the maternity service stopped for a period, after which we tried to restart it. If it provides any reassurance, 10 babies have been delivered, and 20 mums are booked in for each of the next couple of months. We are only four midwives short, and the trust is making every effort to recruit them. When one service ceases and a new, exciting and radically different service begins, people are sometimes a bit anxious. As the unit proves itself, midwives will be attracted to working in that environment in the same way that mums have been attracted to having their babies there. Denise may wish to comment on that as a midwife.

Ms Denise Boulter (Department of Health, Social Services and Public Safety):

Mary is right that the break in service led to midwives moving to other areas. We are fortunate in Northern Ireland that all of the midwives are employed, and, because of that, midwives had to

decide whether to move to the new, albeit exciting, unit at Downpatrick. As Mary said, the unit is open and running well, and 10 nice, healthy babies have been born there. That will make it an attractive prospect for midwives, and recruitment will continue until the 24/7 service is provided.

The Chairperson:

Is there no way of telling midwives that they must work in the Downe Hospital? They are paid by the trust, so should a vital service remain closed entirely because they refuse? Is that the way that things are done? In some organisations, employees would not be given the option. If the service is required in a hospital and women want to have babies there, the midwives should be told that they must go. Is that not the way in which the Health Service works?

Dr M McCarthy:

In everything that we do in the Health Service, we try to match the service and patient needs with the required staffing and resources. In doing so, we must recognise employment law and the right of people to apply, or not, for particular posts.

The issue is how to attract people to a unit, and we are optimistic that the recruitment at the Downe Hospital will be completed. The progress over recent weeks and months has been good. It is hoped that the fact that the unit is open, established and of interest and benefit to the local population will help to attract midwives. It is always difficult to anticipate how things will develop, but the picture looks much better now than it did a number of months ago.

The Chairperson:

I have a few more questions that I will ask at the end of the meeting.

Mrs O'Neill:

Thank you for your presentation. Once the review is complete, it will go back to the Department, so it will be some time before a maternity strategy is in place. I want to pick up on a few issues about workforce planning that the Department can consider in the meantime.

In this morning's evidence, it was mentioned that 50 midwives retired last year, 50% of whom worked in the Southern Trust area. We must strike a balance, because it is necessary to have experience and to be able to attract new midwives. Is there proper workforce planning, and are enough midwives being trained?

Dr M McCarthy:

Workforce planning is critical to everything that we do. The planning and anticipation of our future needs is important, and it is something of a science and, at times, something of an art.

Denise is best placed to provide a bit more detail, as she is much closer to the specific workforce planning, particularly for midwifery.

Ms Boulter:

For some time, we have been aware of the age profile of midwives and of the need constantly to review the situation of midwives who work part time. We are aware of the associated issues, and, over the past number of years, we have increased the number of training places for midwives accordingly. We have worked closely with maternity services to determine how high that number can go. Approximately 170 student midwives are in training, and there are 65 places each year for students.

There are two ways to become a midwife, either directly via a three-year programme or through being a registered nurse, which requires an 18-month programme. We balance those numbers according to the needs of maternity services. At present, 35 people are enrolled on the 18-month post-registration programme and 30 people on the three-year direct-entry programme. That ensures that midwives get through the training programme more quickly.

We also had discussions with the various trusts, particularly the Southern Trust. We recognised that there was a particular problem in the Southern Trust and, after discussion with the trust, 12 extra places for midwifery training in the local area were commissioned. The hope was that, once qualified, those midwives would work in the Southern Trust area. Those midwives have completed their training and now work in the area.

We also supported the development of a programme of training for maternity support workers, because midwives must be free to do the job of midwifery. There was a pilot programme in the Southern Trust last year. The final programme for the development of maternity support workers has been developed and is due to start in June 2010. That will ensure that maternity support workers are available to give midwives more support in the future.

There is also a UK-wide programme, Midwifery 2020, which is considering the future of midwifery throughout the United Kingdom. All four countries are taking part in the programme, a major element of which concerns workforce planning for midwifery and how that should develop. Northern Ireland has been deeply involved in that programme, which is due to present its findings in September 2010.

Mrs O'Neill:

One of the RQIA recommendations concerns the lack of a specific policy for consultant midwifery posts. We all recognise the benefits that that role will bring, especially given the 30% increase in Caesarean section rates in every trust area except one. That post would create a greater focus on normal, rather than medicalised, births. In the absence of a strategy, is the Department doing anything about that?

Ms Boulter:

You are correct in saying that no consultant midwifes are in post in Northern Ireland at present. Primarily, the consultant midwife role is one of leadership, and although no one occupies that post, in many senior midwives, in bands 8a, 8b and 8c, provide leadership throughout Northern Ireland. The concept of a consultant midwife is relatively new. None of the other three countries has the number of consultant midwives recommended by the standards. The role of consultant midwife is important in providing leadership and promoting normality throughout the service. It will be discussed as a part of the development of the maternity strategy that has just been announced.

Mrs O'Neill:

May the Committee have a copy of review group's terms of reference?

Dr M McCarthy:

We are happy to provide that. We will discuss, and perhaps tweak, those at our first meeting next week, after which I will send a copy to you.

Mrs O'Neill:

Will perinatal services be included in the review?

Dr M McCarthy:

Yes. The review covers the entire ante-natal and postnatal periods. I am happy to provide the terms of reference.

Ms S Ramsey:

As long as we do not have to wait nine months for them.

The Chairperson:

Conall, may I remind you that the subject today is the RQIA report on particular aspects, rather than a general discussion, of maternity services. We are letting the Department away lightly to some extent.

Mr McDevitt:

I want to pick up on a question that I asked about NIMATS during the earlier witness session. There is a lack of clarity on when that came into being. Is anyone able to clarify that for me? Also, I am interested in the level of monetary investment that has been made in NIMATS to date.

Ms Hinds:

I will give you such information as I have been able to find out. The history is interesting: in 1989, Professor Harley, who was based at the Royal, worked with staff to create NIMATS, which was a bottom-up system. The investment made in 1989 was in the region of £100,000, which was a sizeable sum then.

Since then, NIMATS has been maintained for a nominal amount by the Department's directorate of information systems. Recent investments have been of the order of tens of thousands rather than hundreds of thousands of pounds. The investments have been used to modify laboratory services and to carry out technical work to make the system work more efficiently. It now operates in four of the five trusts and will be in place in the Western Trust before the end of the year. The system is driven from the bottom up. One could argue that there should, some day, be a modern all-singing, all-dancing system. However, despite being clumsy at times, NIMATS houses a significant amount of information. The challenge is to use that information in a more proactive way than has been the case to date.

Mr McDevitt:

I must also pick up on Mr Galloway's point about the debate that seems to be taking place about standard 4.6 and the new standard that you introduced, which is standard 7.4. I am a layman but also the father of three children, all of whom were born through Caesarean section. One was an emergency, and the other two were scheduled. I presume that you are not suggesting that the only time that an anaesthetist is required is in the event of a Caesarean section?

Mr Galloway:

Not at all.

Mr McDevitt:

In that case, there is no direct correlation between standard 7.4 and standard 4.6?

Mr Galloway:

I introduced standard 7.4 to reflect the fact that, when an emergency Caesarean section is required, every trust must provide the anaesthetic cover —

Mr McDevitt:

That is not what standard 7.4 states. It refers to an emergency Caesarean section, but not to an emergency anaesthetist.

Mr Galloway:

That is implied.

Mr McDevitt:

Nevertheless, an emergency Caesarean section would be only one of any number of examples.

Mr Galloway:

Absolutely.

Mr McDevitt:

I will return to standard 4.6: are you of the view that it is adequate, has been properly thought through and is an appropriate standard for the Health Service in this region? Alternatively, do

you share the view that was expressed earlier today that perhaps standard 4.6 is clinically led?

Mr Galloway:

The standards are clinically led. They are produced by the four Royal Colleges. It is important to understand that they are, essentially, clinical. However, they are important benchmarks for the development of maternity services in Northern Ireland.

The Belfast Trust probably expressed the flip side of that. The risk management arrangements that trusts put in place, particularly in smaller units, to ensure adequate out-of-hours cover, for example, are vital in ensuring that the services provided by the trust are proportionate to the resources available to it and that those services meet the needs of women and babies.

I am not trying to draw a wedge between standard 4.6 and what the Health Service is trying to achieve. Rather, I am trying to illustrate that the standard is one avenue that we want to be progressed in the move towards that achievement. Against that, however, one must weigh up the risk management approaches that the trusts deploy to ensure that the services that they provide are safe.

Mr McDevitt:

I am not sure that I entirely understand. As was explained to us this morning, the standards, which are clinically led, draw on the relationship between the degree of consultant cover required per number of cases that are likely to come through. It is, therefore, a direct function of the number of cases. Earlier today, it was expressed that that was not a particularly sensible way to plan cover.

Mr Galloway:

I do not think that the Belfast Trust would agree that a direct correlation can be made.

Mr McDevitt:

So there is no relationship between —

Mr Galloway:

I am not saying that. Obviously, there is a relationship between the size of the unit, the number of births and the number of staff available. However, that may not be a black-and-white relationship

in every case.

Mr McDevitt:

In that case, why is the standard being used?

Mr Galloway:

As I am sure you heard this morning, the standards were applied by the RQIA, because, at the time of its review, those were the extant professional standards in the United Kingdom.

Mr McDevitt:

A standard is introduced against which every trust proceeds to fail, with the exception of the South Eastern Trust, which is deemed to have only partially achieved it. Subsequently, that standard is set as a benchmark. That leads to an important debate on whether it is a false standard. It seems to be an unusual system.

Dr M McCarthy:

You are right that it creates some complication. Nonetheless, the standards were chosen by the RQIA and have not been formally endorsed by the Department. However, the RQIA began its review prior to the NICE standards being available and receiving endorsement, and timing was, therefore, an issue. The standards represent an important direction of travel and a desired destination. However, as David rightly said, that must be balanced with other priorities for the anaesthetic service. That is not to take away from the importance of having the appropriate anaesthetic support.

I have worked in obstetric units and know that those units that have extensive and appropriate anaesthetic support often experience peaks and troughs in demand. Even with the best support and the best staff, one could still hit a night on which there are many unanticipated deliveries. That is the nature of the service. In that respect, it is important for service providers to match their resources with the anticipated need. It is also important to be able to respond quickly to any unexpected increase in demand and to respond to emergencies as they arise.

The evidence from the services is that medical, nursing and midwifery staff, and the trust staff as a whole, respond to those events quickly. I can see how the wording in that standard could lead one to regard it as not totally compatible with everything else. There is, however, no

philosophical conflict.

Mr McDevitt:

Are you happy to adopt that standard as policy?

Dr M McCarthy:

The RQIA report made it clear that those standards were not endorsed formally —

Mr McDevitt:

I understand that, but, looking forward, are you likely to be happy to adopt that standard as policy?

Dr M McCarthy:

We will consider which standards should be adopted as formal policy. We have adopted and endorsed a number of standards, primarily those from NICE, which we recognise as the national body for evidence-based standards. As we progress the regional maternity services review, we will consider standards of care across the journey of women through pregnancy and delivery.

Mr McDevitt:

My final question is not related directly to the RQIA report, but it is relevant. Are you happy with the level of cover for paediatric pathology services in the region?

Dr M McCarthy:

To answer that, I would need to check the specific detail. For many years, the paediatric pathology services were a tiny, discrete specialty. At various times, there have been issues about whether those services were sufficient to meet needs. We have specialists in the area who are highly skilled. Some years ago, we had difficulties with recruitment and retention in that specialty, and, around and after the time of the human organ inquiry, an incredible focus was placed on everything connected with paediatric pathology. We recognise that, at that time, there were pressures on the system. I would have to examine exactly what level of cover is in place today.

Mr McDevitt:

I wonder whether that is one of the 37 recommendations in the North/South feasibility study, on

which we could attempt to achieve the economies of scale that might be necessary to justify a world class paediatric pathology service on both sides of this island's border.

Dr M McCarthy:

I do not have the detail about the current provision of perinatal services, and I do not have detail on perinatal services outside Northern Ireland.

Mr McDevitt:

Are you aware of the feasibility study?

Dr M McCarthy:

I am aware of the feasibility study, but I was not aware that we were to discuss that today.

Dr Deeny:

I apologise that I was unable to attend this morning's session. The recommended standards for the availability of anaesthetists have been discussed. Is the Department likely to adopt those recommendations? Where does that place the stand-alone, midwifery-led maternity units, as opposed to the consultant-led units? What is the Department's response likely to be?

Dr M McCarthy:

Access to anaesthetic support is an important aspect of consultant-led services for emergency Caesarean sections, other emergencies that may arise and for pain relief by epidural. The concept of the stand-alone units is that they are midwifery-led and, therefore, the midwife provides care throughout the process of delivery. It is expected that women who are deemed fit to deliver in a midwifery-led unit will not require any intervention. Those women are expected to have normal deliveries and require only the care of a midwife and supporting staff. Such deliveries should not require medical intervention from an obstetrician or an anaesthetist. In that respect, the element of risk that any woman will be exposed to during pregnancy will be keenly assessed to ensure that she is an appropriate individual to deliver safely in a stand-alone unit without any anticipated medical intervention.

(The Acting Chairperson [Mr Buchanan] in the Chair)

Dr Deeny:

I am glad that you clarified that. The Minister has said that women's needs are an important issue that must be addressed. It is important that there is a future for midwifery-led units.

More and more, hospitals' futures are being jeopardised, not only because of the loss of maternity units, but because they are losing facilities throughout the secondary care sector. The reason offered is that facilities are being closed on safety grounds, but safety has become an issue because we cannot attract staff. It is incumbent upon the Health Committee and the Assembly to start to address that issue. The Committee's scrutiny function is still embryonic, given that it has been in existence for only the past two and a half years.

As a doctor, my next statement will not win me any friends among my professional colleagues. However, we have reached the stage at which medical staff — doctors, consultants, junior doctors and midwives — must be told that the situation in which they want to work and live only in Belfast cannot continue. That has a serious impact on areas outside Belfast.

I was pleased, but also shocked, to hear that our ratio of midwives to mothers is good. That is wonderful to hear. I had thought that it would be extremely problematic to attract midwives, as well as consultants and junior doctors. There are major problems with staff numbers, and it is extremely difficult to persuade people to move out of the city of Belfast.

The Scottish Parliament has an arrangement with the Royal Colleges whereby it is written into the contracts of some consultants that they must rotate locations. That system enables consultants to provide the necessary services in six different hospitals. That is the future: by rotating staff, we would be able to provide the services that are needed to the rural population of Northern Ireland. I am interested in hearing your views on that.

I presume that the regional review of maternity services will incorporate the central Ulster area. Four of the five witnesses currently before the Committee are women. They and their husbands will agree with my next point. It cannot be right that I have met three mothers who left their homes to live elsewhere — two to Belfast and one to Enniskillen. Their babies were due during the winter months, and they left their homes because they felt uncertain. Those women were worried about going into labour suddenly and having to deliver their babies on the roadside. That demonstrates to me that the needs of women in central Ulster are not being met.

The situation mirrors that of acute services. As a result of losing maternity units in Magherafelt, Dungannon and Omagh, a large section of the population is worried, and those concerns must be addressed. I do not like to make comparisons, but central Ulster has lost three maternity units. Therefore, people question why there are midwifery-led units in Downpatrick, which is only half an hour from Belfast, and in Lagan Valley, which is just up the road from Belfast. Downpatrick is in my native territory, and people there deserve that unit, but we cannot have one rule for the east coast of Northern Ireland and another for the west. Mothers in central Ulster feel that their needs are not being met and that they, in contrast to mothers in other areas of Northern Ireland, are not being listened to.

Dr M McCarthy:

I give you an absolute assurance that the regional review will examine maternity services for the entire population of Northern Ireland, regardless of geography or any other differential.

Ms S Ramsey:

Will that include the border counties in which there are particular issues?

Dr M McCarthy:

The review will cover the entire population of Northern Ireland. That means every woman, and, behind every woman, every family. People are interested in the access and quality of care throughout the region. In undertaking the review, we will engage with stakeholders and users of the service. We will listen to and take account of what we hear during the consultation exercises. We will also visit every trust to hear the views of the staff and service providers. Thus, we will take stock of views from the widest possible range of individuals. I assure members that our review will be conducted on a regional basis.

Dr Deeny:

You will listen to management in the trusts, but GPs are the patients' advocates, and I hope that we speak up them. If you do not listen to mothers in central Ulster, who feel that they have been forgotten about, how will you listen to, assess and determine the needs of women throughout the region?

Dr M McCarthy:

I hope that the women in central Ulster will be assured that they have not been forgotten about. We have not yet developed the methodology for the review, so I cannot speak about the specifics, nor have we held our first formal meeting to determine what we will do. When we want to take users' views on other services, we often do so through the Patient and Client Council, rather than visiting particular hospitals or sites. The council can access local community groups and obtain a reasonable cross-section of views. We will also liaise with the maternity liaison groups, which are ideally placed to interface with users. We will find a methodology that provides access to a cross-section of the population, but we have not yet determined what form that will take.

Dr Deeny:

I am sorry for firing questions at you constantly. When you look at the map, do you not feel, as I do, that central Ulster has needs throughout healthcare provision? Specifically on the subject of maternity services, the issue of the three consultant-led units that closed without a single replacement must be addressed. Does the Department not accept that?

Dr M McCarthy:

We will examine the access to services, the quality of services and sustainability in the round. As we progress the review, we will take account of all factors throughout Northern Ireland. I hope that the report, on its future publication, the report will reassure the Committee of the rigour with which we have examined the current service and arrived at our recommendations. The work is due to commence this week, and the review group comprises excellent people. Our terms of reference will direct us to what needs to be done, and we will carry out that work in as participative a manner as possible. We hope not to exclude any key group from the review.

Dr Deeny:

A question was asked about the rotation of staff, but it was not answered. Is the Department considering that option? The fact that many doctors, consultants and midwives want to work and live in Belfast means that the healthcare of the rest of us who live far away from Belfast suffers. Should the Department not examine that situation?

The Chairperson [Mr Wells] in the Chair)

Dr M McCarthy:

The patterns of work across all specialties have been changing for quite a number of years. In all trusts, medical staff in particular tend to move around the various trust sites. To ensure that people do not have to travel undue distances simply to visit a clinic, medical staff may perform their surgical list in one hospital and their outpatient clinics in a range of hospitals

Many specialty services are based in Belfast because they depend on a small group of specialists whom it would not be reasonable to disperse throughout Northern Ireland. Many of those specialty services have well-established outreach services to other trusts throughout the Province. For many years, for example, paediatric cardiology consultants have travelled to several different hospitals and, indeed, they have established a tele-link with other hospitals. Therefore, many avenues have been explored and many processes established. New initiatives are always being implemented to ensure that we provide services to the population to the best of our ability.

Mr Gardiner:

I am concerned that there is not a quota of anaesthetists in hospitals. They work from 9.00 am to 5.00 pm, Monday to Friday. Outside those hours, GPs have to be called in when necessary. In the past, I have sung the praises, and rightly so, of Craigavon Area Hospital, because the midwifery-led unit there has been brilliant. People even cross the border to have their babies delivered in the Southern Trust area. Although that is testimony to the service in Northern Ireland, it places an extra burden and responsibility on the Southern Trust and, in particular, the midwifery unit at Craigavon. What do you intend to do about anaesthetists? It is unfair to call in a doctor who is not fully qualified to anaesthetise patients when something goes wrong. The RQIA target is not being achieved.

Dr M McCarthy:

I will set the scene by explaining the overall provision of anaesthetists throughout Northern Ireland. There are about 212 consultant anaesthetists plus those who are in training grades. That compares favourably with the ratio in other parts of the UK. Indeed, it is somewhat better.

Anaesthetists cover a wide range of services, including surgery, obstetrics and intensive care. They are often called in to deal with emergencies, because they are highly skilled individuals who are extremely proficient in resuscitation.

The details of anaesthetic provision in consultant-led obstetric services are, to some extent, reflected in the RQIA report. In most trusts, there will be an arrangement whereby, if the first anaesthetist who is on call for the hospital's obstetric unit has been called in to say that he or she is busy, the second anaesthetist will be called in. That is how the normal rota operates.

Mr Gardiner:

How soon will that be put into operation?

Dr M McCarthy:

That arrangement is already in place in the trusts. An individual will be at home and available should he or she be needed.

Dr Gardiner:

As Dr Deeny said, could that mean that an anaesthetist who is at home in Belfast could be called to Craigavon Area Hospital?

Dr M McCarthy:

The presumption is that the individual is readily available and close at hand. Normally, he or she is in the hospital and ready to perform his or her duties within 30 minutes. The trust also ensures that those individuals who expect to be called in to anaesthetise patients for surgery or obstetrics are qualified and have the necessary skills and expertise. Therefore, they are not trainee doctors in junior grades. They are competent to anaesthetise, which is, of course, a key requirement and one that reassures the public.

Mr Gardiner:

Witnesses from the Southern Health and Social Care Trust, who are due before the Committee later today will, no doubt, say something else when I put a similar question to them. I will ask them whether they are satisfied with the level of support that they receive.

Mr Buchanan:

Thank you for coming and taking our questions today. It has been an interesting session. Nearly every one of you has used the same two words: "safety" and "equality". I hope that when you talk about equality, you mean equality for everyone in Northern Ireland, as opposed to those

living in certain areas. Equality should benefit people who live in my constituency as much as it benefits the rest of Northern Ireland. Will you inform the Committee how the maternity strategy will address the huge deficit in maternity service provision in some areas of Northern Ireland?

I will not mention Omagh specifically, but I will mention County Tyrone. Perhaps, for the Committee's benefit, you will state how many obstetric-led and midwifery-led services there are in County Tyrone. It would be good for the Committee to hear that information from you folks.

The number of births is lower in some units than in others. I note that the service at Lagan Valley Hospital has been reduced to a midwife-led maternity unit, and that is, I presume, because the number of births there has fallen. If that is the case, will the strategy strengthen the smaller maternity units or lead to further devastating consequences for them? I note that the number of births at a few of the units is only a little higher than at Lagan Valley Hospital.

Dr M McCarthy:

You mentioned County Tyrone. There are 11 units in the region, and we tend to consider those not by county, but by the location of the hospital base.

Mr Buchanan:

With due respect, every other county has a maternity unit. How many maternity units are there in County Tyrone?

Dr M McCarthy:

Women from County Tyrone are likely to deliver in Altnagelvin Area Hospital, the Erne Hospital or, if they have specialist needs, in Belfast.

Mr Buchanan:

All of those units are outside County Tyrone.

The Chairperson:

The answer is that there are none in County Tyrone.

Dr M McCarthy:

By and large, women from County Tyrone deliver in Altnagelvin Area Hospital or Belfast.

The regional review will examine the provision of services for the population and consider how to strengthen those services to ensure that they are safe, of high quality, sustainable and accessible. We will examine the services, rather than focusing on individual units. The focus will be on the needs of the regional service across Northern Ireland based on the population and on our ability to provide the appropriate care in the right place for everyone who is pregnant or delivering a baby.

Mr Buchanan:

The Mater Hospital, the Erne Hospital and others have birth rates that are only slightly higher than that of Lagan Valley Hospital. Is there a danger that, if their yearly birth figures do not rise, their services could be reduced from obstetric-led units to midwifery-led units?

Dr M McCarthy:

We need to consider the entirety of the service as we progress with the review. It would be unfair to prejudge any aspect of it, because we have yet to meet. We will have to consider the issues methodically. Particular issues were associated with Lagan Valley Hospital, including a difficulty in providing paediatric support during delivery. We want there to be appropriate levels of paediatric support in all consultant-led units.

The need for a paediatrician to resuscitate in an emergency is often unanticipated until after the birth, when the baby is not breathing adequately or looks blue. The presence of a paediatrician acts as a safety net and is important in the delivery of consultant-led obstetric services. That was the challenge faced at Lagan Valley Hospital and one factor that led to the change in the nature of the service provided there. The new unit, which will be established there in due course, will provide extremely good care to women who have been assessed as suitable to deliver there.

The Chairperson:

Thank you very much. I have one final point. This morning, the Belfast Trust said that it had submitted a bid for £2 million to the Department to improve maternity services. Is there any news on the progress of that bid?

Dr M McCarthy:

Mary Hinds may have further details of that bid. It will probably be with the Health and Social Care Board and the Public Health Agency for consideration.

Ms Hinds:

As with many other bids, it will be considered as part of the outcome of the joint commissioning plan. Unfortunately, I cannot give members any assurance on spending at present. The plan is being developed and finalised, and it will be submitted to the Minister for his consideration. I believe that the Minister will talk to the Committee in June.

Ms S Ramsey:

That is a no, then.

Ms Hinds:

I am not saying no, Sue. I am saying that, at this stage, the plan is not finished.

The Chairperson:

This past day or two, your phone has been red hot, Mr Galloway, albeit for other reasons. Therefore, we are glad that you could spare the time to talk to us on such an important matter. The discussion has been most useful. Thank you very much.