Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Report of the RQIA on the Review of Intrapartum Care in Northern Ireland: Regulation and Quality Improvement Authority

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 Sam Gardiner
Mr John McCallister
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:
Mr Glenn Houston)
Mr Phelim Quinn) Regulation and Quality Improvement Authority
Dr David Stewart)

The Deputy Chairperson (Mrs O'Neill):

I welcome Mr Glenn Houston, chief executive of the Regulation and Quality Improvement Authority (RQIA), Mr Phelim Quinn, director of operations and chief nursing adviser, and Dr David Stewart, medical director. In case you are wondering, I am in the chair because the Chairperson has been to the dentist, and his mouth is still frozen. I invite you to make your presentation, after which members will ask questions.

Mr Glenn Houston (Regulation and Quality Improvement Authority):

Thank you very much for this opportunity to present the findings and recommendations of the RQIA's review of intrapartum care services in Northern Ireland. We extended an invitation to other members of the review team to join us today. However, pressing commitments mean that they are, unfortunately, unable to be here.

The significant review forms part of our comprehensive programme to examine the quality of health and social care in Northern Ireland. The review concentrated on the care that is provided to women during labour and delivery. It focused on the safer childbirth standards that were published by the four Royal Colleges in October 2007.

Several important factors, including the increasing birth rate in Northern Ireland, led to the RQIA's carrying out the review. In 2008, there were 25,575 births recorded, a figure that was 5% higher than in 2007 and the highest increase since 1991. Other factors included the changes in 2007 to the trust boundaries and to the management of maternity services, the serious adverse incidents that have been reported in maternity services regionally and nationally, and the comparatively high levels of obstetric intervention rates in Northern Ireland. We also noted that reviews into maternity services had been completed by health regulators in other regions of the United Kingdom.

The review was undertaken by a panel of leading independent experts in midwifery, obstetrics and anaesthetics from across the United Kingdom. The team also included a lay reviewer, the vice-president of standards for the Royal College of Obstetricians and Gynaecologists (RCOG), a consultant obstetrician and a consultant anaesthetist from Guy's and St Thomas' NHS Foundation Trust — a leading teaching hospital in London — and the head of child health and maternity care from the National Patient Safety Agency. I will now hand over to my colleague, Phelim Quinn, who led the review for the RQIA.

Mr Phelim Quinn (Regulation and Quality Improvement Authority):

I will talk first about the review process. In the absence of specific intrapartum care standards at the time of the review, the RQIA decided, as Glenn outlined, to use the safer childbirth minimum standards for the organisation of delivery of care in labour. At that time, it was considered to be a robust framework against which services could be assessed. We also took into account the letter from the Chief Nursing Officer (CNO) and the Chief Medical Officer (CMO), which outlined a

range of recommendations that emanated from the review of maternal deaths, the report of which was published in October 2008.

The methodology for the review involved a self-assessment by each trust and visits by the review team to all 10 maternity units in Northern Ireland. The review included a survey of mothers at 16 weeks after giving birth, to which we received 250 responses. As part of the review assessment exercise, the achievement levels measured the level of both maternity units in each trust. Therefore, when one unit failed to achieve the standard, that was the level that we recorded for the trust.

The review assessed the units against 10 of the safer childbirth standards: organisation and documentation, multidisciplinary working, communication, staffing levels, leadership, core responsibilities, emergencies and transfers, training and education, environment and facilities, and issues relating to clinical outcomes. The report, copies of which have been given to members, contains 43 recommendations, of which 20 apply to the service across Northern Ireland and 23 are trust specific.

The review team found many strengths in the services across Northern Ireland, and it recognised the dedicated and committed workforce who provide safe and effective care for women during labour and delivery. The mothers' survey showed a high degree of satisfaction against the Department's patient experience standards and, more specifically, extremely positive comments were made about breastfeeding support on the labour wards.

The facilities in which intrapartum care is delivered were noted by the review team to be of an excellent and improving standard. Those facilities include the new units at Altnagelvin Area Hospital and the Ulster Hospital. Note was also made of the significant refurbishments that had been carried out at Lagan Valley Hospital and Daisy Hill Hospital.

It was noted that the trusts responded constructively to regional and national serious adverse incidents and that they were addressing major learning points arising from those.

We also identified areas in which the safer childbirth standards were not being met across the service. The team identified challenges and areas that required improvement in, for example, record keeping.

The team identified the need to develop a workforce strategy for maternity services across Northern Ireland and to assess maternity services against the levels that are recommended in the safer childbirth standards. More particularly, a proactive workforce plan is needed for each staff group. The review team also noted that, in a number of areas, particularly the smaller maternity units, the level of consultant obstetrician cover and 24-hour anaesthetic cover, in keeping with safer childbirth standards, was not being provided.

Effective leadership is an essential part of the provision of all health and social care services, and the review highlights the lack of a specific policy for the development of consultant midwifery posts in Northern Ireland. The review team was firmly of the view that support for the development of midwifery-led care and the normalisation of labour and delivery should be accompanied by the creation of those posts.

The team examined core responsibilities. Midwives must provide one-to-one care for women in labour. It was recognised that, at times, trusts struggled to provide that, although a number of interventions had been made to try to maintain that standard.

All trusts must have in place an agreement with the Northern Ireland Ambulance Service to secure safe emergency transfers.

On the issue of training and education, the review team highlighted the need to afford to staff important protected training time to meet mandatory and other training requirements. That must be addressed in the context of an overall workforce strategy.

The review team found that the current Northern Ireland maternity services information system (NIMATS) was not available in some of the units. Where it was used, it provided an essential source of information about the clinical activity and outcomes, and it informed improvements in patient safety.

The review team recommended that the capacity of units be reviewed, taking into account the significant impact of the proposed changes of the reprofiling of services on the Lagan Valley Hospital site.

Finally, the findings of the review team led it to recommend that a strategy for maternity services in Northern Ireland be developed to set a clear direction for services in the future.

Mr Houston:

I wish to conclude by saying that the RQIA and the review team acknowledge the commitment and dedication of staff who work to provide safe and effective care for women during labour and delivery. The findings and recommendations of our review will help to support further improvement in services. We also welcome the Minister's announcement of the development of a maternity service strategy for Northern Ireland, which will take account of the recommendations of the review.

The Deputy Chairperson:

Thank you for your presentation. Many members will want to ask why, given that the review was finished over a year ago, it took such an inordinate length of time for the report to be placed in the public domain. I acknowledge that an election took place during that time.

Mr Houston:

The review was one of several such programmes in which the RQIA was engaged. Originally, we set a target of January 2010 for the publication of the report. The five individual reports were ready and available earlier this year, but, during consultation with some of the Department's policy leads, it was suggested to us that an overview report would be helpful. We considered that suggestion, agreed to it and prepared an overview report to accompany the five individual trust reports. Our intention was to publish immediately after Easter, but the election purdah period meant that we deferred publication until this week.

The Deputy Chairperson:

One of the report's major recommendations is that a maternity strategy be developed. The Royal College of Midwives has been calling for such a strategy for some time. What should be included in that strategy, and what difference do you envisage it making?

Mr Houston:

I shall ask my colleague Mr Quinn, who was a member of the review team, to comment on that, after which Dr Stewart will add his observations.

Mr Quinn:

The review found possible policy and planning gaps in several key areas. The recent re-profiling of services across Northern Ireland, for example, involved the closure of some smaller units and the centralisation of services. The team felt that a clear direction had to be set for the future delivery and configuration of services.

Workforce issues were also regarded as central to the delivery of a strategy, as was the profile of service delivery, which determines whether services will be obstetric-led or midwifery-led. The planning of workforce needs for maternity services in Northern Ireland is an important element in achieving a balance between the requirements of inpatient and community care and those of training. We place great emphasis on the requirement to protect training for the obstetricians, midwives and anaesthetists who deliver the service.

Dr David Stewart (Regulation and Quality Improvement Authority):

One of the issues to be considered when planning any service is the future demand. In maternity services, the number of births has changed significantly from the figure that was predicted some years ago. As the number of births rises, it changes the need for services in the future. Therefore, the strategy must take on board the changing pattern in births across Northern Ireland. Another key issue that emerged from the review was the need to ensure that a change in one unit is profiled across the system. In that way, when a particular unit is set to close or change the nature of its services, other units can plan to take up the additional demand.

Significant developments in maternity services are ongoing, such as the opening of the new midwifery unit in Downpatrick and the increased potential for midwifery care. However, the review team's view is that, to facilitate logical planning, all such developments must be pulled together into a strategy for the whole of Northern Ireland. Thus, when a new unit is due to open, thought must be given to the impact that that will have on neighbouring units.

Mr Houston:

The RQIA review deliberately concentrated on the care that is provided to women during labour and delivery. The wider strategy will include a more comprehensive examination of antenatal and post-natal care, in addition to the care provided during the intrapartum phase.

The Deputy Chairperson:

The sooner we receive that strategy, the better. The statistics show a rise in the rate of Caesarean sections rates. An increase in the number of consultant midwives might return the focus from medicalised births to normal deliveries. The strategy, therefore, is crucial.

The report stressed that the trusts should ensure the harmonisation of their policies. We talked about the tendency for some legacy trusts to bring their policies with them to the newly merged trusts. However, more than two years have elapsed since that merger. Are there still areas in which the harmonisation of policies has not taken place?

Mr Quinn:

At the time of the review, in some instances, important policies had still not been harmonised. The review team made it clear that that harmonisation needed to happen as quickly as possible.

The Deputy Chairperson:

Has it happened since the review?

Mr Quinn:

We are not aware of whether it has, because we have not followed through on that.

Mr Wells:

The right side of my mouth is frozen, so I did not feel up to talking too much. Standard 4 in your report deals with the level of staffing. The problem, which also made the news today, is one of getting consultants, senior midwives and junior doctors — particularly senior midwives and consultant midwives — to fill certain positions. It always strikes me as strange that society pays consultants a substantial salary, yet it does not seem to have the authority to tell those folk to work in the hospital that needs them. Consultants are reluctant to move out of the greater Belfast area. That had an impact on the Downe Hospital too, where the midwifery-led unit did not get off the ground in time because senior staff were not prepared to move there.

Have you identified a way in which the Department could crack the whip? Given that senior members of staff are paid £150,000 a year, can the Department not insist that they go where they are needed, whether that is Altnagelvin, Erne or Downe? The reluctance to move is a continual theme in hospital provision in Northern Ireland.

Mr Houston:

As part of the review, we examined the standards, particularly standard 4, which referred to the availability of consultant obstetricians and anaesthetists, as well as to the importance of clinical leadership in midwifery. The issue is one of making the best use of the total time available. Jim, the review examined, for example, the availability of an obstetric presence in the labour ward, which is a major safety consideration. The standards set out particular targets that relate to the number of births and their complexity.

Each of the five trusts operates two maternity units. Some have midwifery-led units, some have obstetric-led units, and some have both. It is a matter of making the best and most effective use of the total available resource across the entire maternity service.

Mr Wells:

Is staffing much more problematic in rural and more remote hospitals than in the big city hospitals?

Dr Stewart:

The staffing of a range of units is a challenging area. One of the major challenges in the recent past has been the introduction of the 48-hour rule for junior staff, which means that every unit must have a sufficient number of staff to run a rota. All units require a significant number of staff, and, therefore, the issue is not so much that there is an oversupply of staff in one unit. Rather the issue is one of recruiting a sufficient number of staff to run units across a range of areas.

There has been a significant change in the period since the consultant contract was introduced. Each consultant is now required to have an agreed job plan with his or her employer.

Mr Wells:

It is awfully decent and kind of them to agree to that.

Dr Stewart:

The review has shown that each unit requires consultants on the ground. The concept of prospective cover in the safer childbirth standards is about encouraging units to have dedicated

cover on the wards. Dedicated cover means that a consultant is present on the ward, rather than seeing outpatients or conducting surgery. We recognise that that has placed a demand on all units to increase their level of consultant staffing. The review team found variable progress across units in that respect. However, it found that all trusts aimed to increase the amount of dedicated time.

The pressures on consultant staffing would not be relieved by moving consultants across Northern Ireland. The review required every unit to examine its level of consultant staffing.

Mr Houston:

Clinical leadership is a key issue. We found that some trusts were operating a consultant-of-the-week system, whereby primary responsibility for the labour ward was shared across the team on a rotational basis. Other trusts identified a named-lead obstetrician with responsibility for the labour ward, which was also a useful way of providing effective clinical leadership. We also saw evidence of trusts that operated labour-ward forums. Those are multidisciplinary forums in which the medical and midwifery staff come together to consider particular aspects of the management and delivery of safe and effective services. Those are all positive and proactive ways of dealing with patient safety.

Mr McDevitt:

Thank you for your presentation. I am interested in the Northern Ireland maternity services information system. When was NIMATS introduced?

Mr Quinn:

I cannot give you an exact date, Conall, but the system has been in place in several units for some time. The key issue for the review team was that NIMATS had still not been applied in all units and across all services in Northern Ireland. We saw good examples of how information from NIMATS was used to inform clinical audit and how, subsequently, the information from clinical audit was used to change and improve services. In the Ulster Hospital, for example, significant multidisciplinary work was carried out on the reduction of Caesarean section rates.

The task is to ensure that the system infiltrates every maternity unit and that it is properly used. Some trusts, such as the Belfast Trust, have a NIMATS co-ordinator, whose provision of clinical and outcome information to staff is extremely helpful.

Mr McDevitt:

What level of investment has been made in NIMATS to date?

Mr Quinn:

We did not look into the amount of investment. We investigated only whether NIMATS was in place and whether clinical information was available to the trusts to enable them to react accordingly.

Mr McDevitt:

Although you mentioned some good examples of the use of NIMATS in the Belfast Trust area, you rarely declared that the standards elsewhere were more than partially achieved. Even in the Belfast area, you declared that the standards were only partially achieved. In the Western Trust, Altnagelvin Area Hospital and the Erne Hospital simply do not use the system. I presume that the system has been around for five or six years.

Mr Quinn:

Yes, if not longer.

Mr McDevitt;

What are the barriers to the adoption of NIMATS? What would facilitate the successful cultural shift to allow the system to lead to benefits for the patients and improved clinical services?

Mr Quinn;

David might want to comment further, but, at the time of the review, the system was not in place in the Western Trust area. The trust was using manual systems of information gathering and using clinical outcome data from those to inform changes in the service. However, at the time of the review, the trusts declared that they were moving towards the adoption of the NIMATS system. We have not followed through to ascertain whether that has happened.

Mr McDevitt:

In your opinion, is it a priority area?

Mr Quinn:

The safer childbirth standard states that good clinical information is required to underpin a safe service. All modern services require that level of information. The vice-president of the Royal College of Obstetricians and Gynaecologists made several demands of us in relation to gathering information in advance of the review. However, we found it difficult to gather that information in a consistent way across Northern Ireland. Our view is that that information should be available.

Mr McDevitt:

Perhaps we could look into the cost of the investment to date.

The Committee Clerk:

The departmental officials will be here later, and you can put that question to them.

Mr Gardiner:

You are welcome, gentlemen. Do you have a record of the complaints that the Department received over the past two years? How many stillbirths were there? How many ladies died after giving birth, perhaps as a result of not receiving certain treatment or attention?

Mr Houston:

At the outset of the review, the team was aware of several high-profile regional and national incidents, and they formed part of the background to and context of the review. We did not gather statistical information on the number of incidents, but all serious adverse incidents are reported and captured, and that information is reported to a central source in the Department. Each of the individual trusts also captures that information through its internal governance arrangements.

Mr Gardiner:

I am sorely disappointed that you do not have those figures. You people work in the system, and yet you do not know how many letters of complaint have been received from mothers who were dissatisfied with the treatment or attention that they received.

Mr Houston:

I understand your point. I may not have explained correctly, but those complaints are initially made to the trust, not to the RQIA. The individual trust investigates the complaints, particularly

about any aspect of maternity services. If we are made aware of a particular complaint, we endeavour to ensure that the complainant receives proper advice, where necessary, on how to follow the complaints policy and protocol.

Mr Gardiner:

Are you saying that you have a stop-gap measure somewhere along the line, so that when you are made aware of a complaint, you can try to raise the standard in an attempt to prevent a recurrence?

Mr Houston:

If someone brings a matter to our attention, Mr Gardiner, it is immediately referred to the appropriate source for investigation. If the complainant subsequently expresses dissatisfaction to us, we contact the trust, if necessary, to ensure that the matter is being properly dealt with.

Mr Gardiner:

The RQIA should be more efficient.

Mrs McGill:

I have a couple of questions on the situation in the Western Trust. The results of the survey of mothers' experience of labour and giving birth in hospital are encouraging. It is important that we commend a trust when it is so deserving, and the results state that 57% of women who were surveyed had complete confidence and trust in the staff who cared for them. That is to be welcomed.

From reading the report, I get the sense that the staff are always trying to do the best they can, sometimes in difficult and challenging circumstances. However, I note that there seems to be a gap in communication across the disciplines in the Western Trust. One issue is that some staff do not attend meetings. How many such meetings are held, and how valuable are they? If some staff have to attend meetings, does that create a staffing gap on the front line? Has any analysis been carried out on the value of the meetings that staff must attend?

Mr Houston:

One of the recommendations on the theme of multidisciplinary working was that a labour ward forum or equivalent should meet at least every three months. The frequency of the meetings is

not particularly onerous. The report on the Western Trust states that the labour ward forum has been established and meets regularly on both sites. We felt that the terms of reference for the labour ward forum required examination to ensure that they were clearly defined and to ensure that meetings were held regularly.

One particular challenge is the sharing of information more widely across the staff group of any organisation. You are right to point out that not all staff would be able to attend a meeting at a given point in time. However, there would be important information to be shared with staff after meetings. The main issue is about making the best use of time.

Mrs McGill:

One of your recommendations is to facilitate the attendance at those meetings of staff from across the trust. What happens when those staff are released to attend, bearing in mind the pressures on staffing?

Mr Quinn:

Senior management in the Western Trust described one key task as the development of that facilitation through videoconferencing. As there is some distance between the Erne Hospital and the Altnagelvin Area Hospital, valuable staff time could be wasted through travelling to meet centrally. The management demonstrated their commitment to trying to establish videoconferencing between the two labour ward forums and other multidisciplinary groups in the service.

Mr Wells:

The numbness from my trip to the dentist is wearing off, and the pain is starting, but I will struggle on. You highlighted the fact that a large proportion of midwives are over 50 years of age. There is no crime in being over 50 years old; it is a perfectly reasonable position in which to be. However, given that there could be problems down the line, are you content that the Department and trusts are taking sufficient action to ensure that enough qualified midwives are coming through to replace those individuals?

Mr Houston:

It is important that you highlighted that point, because it is one of the key workforce issues for maternity services across Northern Ireland, and it formed a significant part of our work during the

review. I will ask my colleague Mr Quinn to comment further on some of the initiatives that the review team identified as part of the trust's work to try to deal with continuity, particularly in respect of the important challenge of providing one-to-one midwifery care for women in labour.

Mr Quinn:

Mr Wells is right to identify continuity as a major challenge, and it must be addressed through the maternity services strategy. However, we noted some good examples of how trusts were trying to meet that challenge. In the Southern Trust area, for example, an accelerated training programme was in place for locally trained nurses to train in midwifery. As those nurses are local, it is hoped that they will stay in the service. A scheme has been developed to train maternity support workers to provide a competent skill mix in the service. Registered scrub nurses and anaesthetic nurses have been employed in theatre duties to free up midwives who were traditionally used in those roles, which drew them away from key midwifery tasks. Several initiatives are helping to address workforce shortages, but the issue must be addressed as part of the wider strategy.

Mr Wells:

The press coverage of the report made much mention of anaesthetists, yet I do not detect the same emphasis in the report. Was there any reason why you chose to highlight the issue in your media coverage and press releases?

Mr Houston:

The availability of anaesthetic cover was examined under standard 4. In any circumstance in which a woman may need a Caesarean section, particularly if it arises as an emergency, it is important, under standard 4.6 that:

"A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available."

We noted that in all trusts, bar the South Eastern Trust, that had not been achieved. However, that was largely because of the arrangements that are in place in the smaller maternity hospitals. I suspect that the extent of non-achievement was one reason for the issue being picked up by the media.

Mr Wells:

The headline referred to fears over the lack of anaesthetists in our labour wards. It almost felt as though that was the main point in the report.

Mr Houston:

It was by no means the main point in the report, but it was mentioned in the consideration of staffing levels in standard 4.6. I will ask David to say a little more about that.

The Deputy Chairperson:

One of the issues that I picked up from the media was that, if an anaesthetist is with one lady when an emergency case is admitted, the hospital may have to call someone else in. Even though a woman's life may be in jeopardy, it can take some time. Is that what the review team found?

Dr Stewart:

The review team focused on a specific issue, particularly in the smaller hospitals, in which the anaesthetists cover other surgical emergencies in addition to obstetrics. Those smaller hospitals may have one anaesthetist on site and another at home. If a general surgical emergency occurs, the second anaesthetist is not, therefore, immediately available to deal with a potential obstetric emergency. Therefore, the reason that the review team awarded that score is that the relevant standard states that an anaesthetist dedicated to obstetrics should be available.

The review team felt that every local trust that does not meet that standard should examine its anaesthetic cover to ensure that there is no risk of an anaesthetist not being available in the case of a second emergency. The potential problem is not the availability of an anaesthetist but that he or she may be tied up with another emergency.

Mr Gardiner:

Have you done something positive about out-of-hours cover yet?

Mr Houston:

Mr Gardiner, page 47 of the overview report identifies the out-of-hours issue, which must be considered in the round. The overall availability of anaesthetic cover is an important consideration, and we chose to identify it as a matter that requires —

Mr Gardiner:

You must make it a high priority.

Mr Houston:

Yes.

Mr Wells:

That should not be rocket science. A range of crucial staff work in maternity: senior midwives, junior doctors, consultants and anaesthetists. Surely you have a table that details the staff whom you expect to need for the next five or 10 years. Are you content that the trusts, in conjunction with the board, are looking forward in their consideration of their staff requirements, so that they will not be shocked or surprised in five years' time?

Dr Stewart:

The standards set out the required level of obstetric cover that should be provided, as opposed to the number of anaesthetists required. After the review, we received an action plan from the Southern Trust that sets out the steps that it plans to take to deal with the issues that have arisen.

The issue comes back to the overall strategy for having sufficient numbers of staff. However, as you said, Mr Wells, a package of care should be produced for the number of staff that is available. The change in the profile of services impacts on that. If a service changes its profile to that of a midwifery-led unit, there is no requirement to provide medical cover. That potentially frees medical staff to support other units. The issue requires consideration across all units.

Mr Wells:

Are you content that that issue is being addressed?

Dr Stewart:

We are content that action is being considered, but we await the outcome of the workforce strategy as part of the overall maternity services strategy.

The Deputy Chairperson:

That is another question for the Department to answer during its evidence session later today.

Mr McDevitt:

The overview report found that the Belfast Trust, the Northern Trust, the Southern Trust and the Western Trust all failed to meet standard 4.6, and it found that the South Eastern Trust only

partially achieved the standard. As far as I can see from studying the matrix, standard 4.6 is the lowest-scoring standard in your report.

Mr Houston:

Mr Quinn outlined in his introductory statement what happened when a trust's larger unit met the standard but its smaller unit did not. In those circumstances, a trust received the rating that it had not met the standard or that the standard had been partially met, as was the case with the South Eastern Trust.

Mr McDevitt:

I will exercise my critical function as a member of the Committee in saying that, from my brief perusal of the overview report, the staffing policies are the weakest. Across the gamut of staffing standards, there are more partially achieved and not achieved scores than in any other part of the report, which is desperately worrying.

I could not get my head around the results for the Belfast Trust against standard 4.3, which rates against your document's recommendations:

"The duration of prospective consultant obstetrician presence on the labour ward".

The report points to the fact that the Royal Jubilee Maternity Service has 40 hours a week prospective consultant cover and that you would like that to be increased. However, the report on the Belfast Trust goes on to state:

"Prospective cover at the Mater is 35 hours and this can be further compromised by the fact that the covering consultant's office is located at a distance from the delivery suite."

Where is the consultant's office?

Mr Quinn:

I will be honest; I cannot remember. On the day of the review, I was at the Royal site rather than the Mater Hospital, because the review team had split up. Those in the review team at the Mater Hospital felt that the distance between the consultant's office and the delivery suite was an issue.

Dr Stewart:

We should explain the background to that particular standard, because it is complicated and goes back to page 40 of the overview report. The safer childbirth standards set out a standard for making progress on staffing levels over a certain period. They are not minimum standards, but

standards towards which the Royal Colleges consider that there should be movement. In that sense, there is a journey towards the achieving of a standard. Category C2 of the table on page 40, for example, shows that there were 5,000 to 6,000 births and that 60 hours of consultant presence should have been achieved by 2008. The consultant presence should increase to 98 hours the next year and to 168 hours by 2010. Therefore, the standards set out a journey towards a greater level of cover.

We assessed the levels at the point of the year that related to the review team's visit to the unit. Even when a particular unit met the standard at the time of the review, it was possible that it would not meet the standard at the next point of its journey.

Phelim will correct me if I am wrong, but the 35 hours mentioned in the report relate to the level of actual cover. Five hours were not subtracted because of the distance from the consultant's office to the delivery suite. Therefore, for 35 hours a week a consultant gives his or her dedicated time to the unit at the Mater Hospital. However, that consultant could, potentially, be in an office that is some distance from the unit. In some other units, you will see that the numbers of hours of dedicated time were fewer than 35.

Mr McDevitt:

Therefore, the critical word in the report is "prospective", which is used instead of "actual" or "effective". In reality, the Mater Hospital has fewer than 35 hours of actual cover.

Mr Quinn:

No. The trust demonstrated to the review team that it had in place 35 hours' cover at that time.

Mr McDevitt:

Is there a problem with the distance between the consultant's office and the delivery suite?

Mr Quinn:

If the consultant who is supposed to be on the labour ward is in his or her office, the distance that he or she must travel to the ward is an issue.

Mr McDevitt:

On the lack of protocols in emergency cover, there are huge inconsistencies across the region.

Some trusts use highly formalised written protocols, and others appear to have verbal agreements.

Dr Stewart:

Standard 7 relates to a formal agreement with the Ambulance Service. Two trusts had a formal agreement in place, two did not, and one was working towards one. The review team feels that there should be a clear written agreement between the Ambulance Service and the trust, which sets out the response arrangements. We are not saying that there is no cover, as the Ambulance Service still provides the required level of cover. Our issue is the lack of formalised written agreements between the Ambulance Service and the trusts in question.

The Deputy Chairperson:

I want to ask about a recommendation to the Southern Trust:

"The trust should develop a specific risk management policy for obstetrics ensuring that this includes a clearly defined trigger list for incident reporting."

Is the Southern Trust the only trust that does not have such a policy?

Mr Houston:

In the overall framework of recommendations in the overview report, some apply to the entire Health Service in Northern Ireland, and several apply to specific trusts. The latter arose from the considerations of the review team that visited a particular trust. The review team may have picked up on a specific issue that it regarded as sufficiently important to form the basis of a trust-specific recommendation.

Mr Quinn:

On visiting the Southern Trust, the review team's impression was that a risk management policy and trigger list did not exist at that time. However, we have received subsequent communications from the Southern Trust on how it is addressing the recommendations.

The Deputy Chairperson:

Is there a midwife with responsibility for risk management in all the trusts?

Mr Quinn:

There is no prescription in the standards for the employment of midwives with responsibility for risk management. However, it is regarded as an effective way to manage risk in obstetric units.

We wanted to highlight that, where it happens, it is seen as good practice and a good way of managing risk in intrapartum services.

Mr Houston:

It is referenced in the report on the Belfast Trust as something that happens to good effect.

The Deputy Chairperson:

Thank you very much for coming along. As you are aware, the Committee will now hear evidence from the Southern Trust, the Belfast Trust and the Department. Thank you for your extremely helpful report.