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: Southern 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 Tom Buchanan
Dr Kieran Deeny
Mr Sam Gardiner
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:

Dr Patrick Loughran	)	
Mrs Mairead McAlinden	)	Southern Health and Social Care Trust
Dr Gillian Rankin	)	
Mr Francis Rice	)	

The Chairperson (Mr Wells):

I welcome the representatives from the Southern Health and Social Care Trust. You are no strangers to the Committee for Health, Social Services and Public Safety. Mrs Mairead McAlinden is the acting chief executive of the trust; Dr Gillian Rankin is the trust's interim director of acute services; Dr Patrick Loughran is the medical director of the trust; and Mr Francis Rice is the trust's director of mental health and disability services and the executive director of nursing. You have been following proceedings from the Public Gallery, so you have a fair idea

of the issues that we have been discussing. There is no particular reason for our choosing the Southern Trust as witnesses; we were looking for an urban and a rural perspective, and we thought that the Southern Trust might give us an insight into that. Furthermore, it is interesting that the trust's maternity numbers are increasing significantly. There were no other reasons for selecting you, either for applause or for criticism.

Mrs Mairead McAlinden (Southern Health and Social Care Trust):
I thank the Committee for the invitation to appear today to discuss the Southern Trust's response to the Regulation and Quality Improvement Authority (RQIA) review of intrapartum care. We have been listening to proceedings and will try to be careful not to repeat information that the Committee has already heard.

The Southern Trust is committed to providing safe, high-quality maternity services. On that basis, we welcome the RQIA review. We think that we provide a good service; we know that there are areas in which we can improve. It is important for us to be benchmarked against best practice standards, which is what the RQIA review used.

We received information today about the key outcomes for maternity services and for perinatal and neonatal mortality. Members will know that Northern Ireland and the Southern Trust perform well against those safety indicators. We also welcome the RQIA review for the reassurance that it provides and for the recommendations — in some cases, very challenging recommendations — that it puts forward for best practice. The high level of satisfaction expressed in the mothers' survey will be welcomed by our staff. There is always room for improvement. It is good to have an independent assessment against best practice standards, and, for that reason, the report is important.

When the RQIA review team inspected the Southern Trust in spring 2009, we used its informal feedback to develop an action plan that we have been enacting ever since. I hope that our briefing paper gives some assurance that we made significant improvements in some of the areas that are highlighted in the RQIA report. However, our colleagues are here to provide that assurance in person.

I would not like to continue without paying tribute to staff, because they are under pressure in our maternity services in hospitals and in the community. Several colleagues around the table

visited those units recently, spoke to staff and fully understand that our staff are highly skilled and committed to their work.

For members who are less familiar with the trust's maternity services, I will spend a few minutes describing them. We have two maternity units. In Craigavon Area Hospital, we have a consultant-led unit and a midwifery-led unit. There are approximately 4,000 births a year in Craigavon, and more than 800 of those take place in our midwifery-led unit. We recently increased the capacity of that unit from 600 births a year to 900, and it is a successful, well-respected and well-used service.

In Daisy Hill Hospital, we have a consultant-led service in a low-risk maternity unit. We do not have planned births there under 32 weeks; there are no planned births for mothers with maternity problems; and transfer procedures are in place. More than 2,000 births a year take place at the Daisy Hill unit, which provides a high-quality, safe service.

Therefore, in total, in the Southern Trust area, we had almost 6,000 births in 2009, an increase of 8% over the past three years. We are committed to providing safe, high-quality care and to facilitating choice. As well as our consultant-led service, we have a midwifery-led service and we also facilitate home births.

In summary, we want to present some of the key issues that are highlighted in the RQIA report for the Southern Trust, the three trust-specific recommendations and some of the general issues on which members have already touched. As operational lead for maternity services, Dr Gillian Rankin will address the specific recommendations that relate to risk management and some of the general recommendations. Our medical director, and the person with specific responsibility in the trust for the medical workforce, Dr Patrick Loughran, will talk about the provision of anaesthetic cover. Our executive director of nursing, Mr Francis Rice, will provide any information that members require about the midwifery workforce.

Dr Gillian Rankin (Southern Health and Social Care Trust):

I will initially specifically address the three RQIA recommendations for the Southern Health and Social Care Trust.

The first recommendation relates to a risk management strategy for obstetrics. The trust has in

place a clear risk management strategy to which obstetric services in both hospitals adhere. We adopted the Royal College of Obstetricians and Gynaecologists (RCOG) extensive trigger list for incident reporting, and we have a fortnightly meeting led by a consultant obstetrician and a lead midwife in the two labour wards, that is on each site. That fortnightly meeting reviews all the incidents that occurred that are included in the RCOG list. The meeting considers what actions are needed to address, and learn from, those incidents. That learning is then disseminated across the entire department through quarterly multidisciplinary governance meetings that are attended by midwives, doctors and other staff, through audit meetings and via a monthly newsletter to all obstetric services staff.

The second recommendation relates to a designated risk management midwife. The trust received funding for such a role and is currently recruiting for the post. For the past two years, we used that funding to co-ordinate cardiotocography (CTG) training for electronic foetal monitoring. Members will appreciate that that is a core risk management issue in obstetric units. To date, the money has been used for that function. That is now well embedded, and recruitment for a risk management midwife is under way.

The third recommendation relates to a consultant obstetric presence in the labour ward. Currently, consultant obstetric cover is present in the labour ward at Craigavon Area Hospital for 40 hours. That was in place at the time of the review and continues to be so. There are ongoing discussions with the Health and Social Care Board about increasing the level of cover.

In Daisy Hill Hospital, we have a low-risk maternity unit. When the RQIA inspection was undertaken in 2009, we had 10 hours of consultant obstetric cover a week. That cover has since increased to 20 hours, and it will increase further to 28 hours by the end of June. A sixth consultant will be employed in Daisy Hill over the next few months, which will increase the consultant obstetric cover on the labour ward to 36 hours a week. Therefore, the issue of consultant obstetric cover in the labour ward has been significantly addressed since the RQIA inspection.

It is also important to address some of the other RQIA recommendations and to highlight the service improvements that have already been undertaken. One such recommendation concerns the implementation of the Northern Ireland maternity services information system (NIMATS), which has already been discussed today. However, I can confirm that both hospitals in the trust

have fully implemented NIMATS, which means that information on practice is available on both sites.

Another recommendation relates to an annual audit programme. We have a full and long-established audit programme in the trust, and an annual report will be published. We have a training programme in place for record keeping. The quality of record keeping is audited as part of the annual supervision of midwives, to which my colleague Mr Rice will refer in more detail.

Users have been engaged in various aspects of our obstetric services. That has included user involvement in the development of the miscarriage pathway, which is an important clinical pathway, to ensure that there is a sensitive and appropriate pathway in place. In the maternity and neonatal units in Daisy Hill Hospital and Craigavon Area Hospital, users were involved in refurbishment and the design of capital works.

Over £5 million was invested in Craigavon Area Hospital in the past two to three years to improve the maternity and neonatal facilities. They include new recovery areas, delivery rooms and a maternity theatre. Mr Gardiner recently visited the new maternity facilities.

We also had the opportunity to invest £1 million to improve maternity services at Daisy Hill, including the installation of a birthing pool in the maternity unit and the construction of a wonderful new neonatal ward, which will open shortly.

I want to reassure the Committee about the standards of safe care. The trust is fully compliant with the National Institute for Health and Clinical Excellence (NICE) guideline on intrapartum care, to which the departmental officials in the previous evidence session referred. It was also mentioned in a letter from the Chief Medical Officer to the Southern Trust in 2008.

Dr Patrick Loughran (Southern Health and Social Care Trust):

A specific requirement in the RQIA report was for the Southern Trust to address the issue of anaesthetic cover. I will start by pointing out the differences between Daisy Hill Hospital, which is a low-risk unit, and Craigavon Area Hospital, which deals with more complex cases. At the time of the RQIA inspection, anaesthetic staffing at Daisy Hill was at a certain level. However, over the past 13 to 14 months, there have been significant changes to anaesthetic cover, which has strengthened.

There is full consultant anaesthetic cover on the Newry site for five days of the week, from 9.00 am to 5.00 pm. During that period, the duties of the anaesthetist range from anaesthetising patients for elective Caesarean sections to carrying out epidurals for pain relief in labour, providing advice on future anaesthesia for patients who have had complications in the past and being available for anaesthetic consultations. The anaesthetist is also responsible for the general organisation of anaesthetic services from 9.00 am to 5.00 pm.

Outside the period of 9.00 am to 5.00 pm, there is a resident anaesthetist who is not a consultant but a specialty grade doctor who is competent in obstetric anaesthesia. That anaesthetist would not be employed in the hospital unless he or she were competent to meet the particular requirements of a woman during an obstetric emergency. Therefore, a resident anaesthetist is available to the labour ward through a 24-hour period: from 9.00 am to 5.00 pm, a consultant is available, and from 5.00 pm until 9.00 am, the cover is provided by a specialty grade anaesthetist who is backed up by a consultant anaesthetist on call who lives within a short distance of the hospital. I can confirm that consultant staff live within a reasonable range and can return to the hospital at short notice.

The requirement to return at short notice would be either to help a staff grade anaesthetist on the labour ward or to return to the labour ward if the staff grade anaesthetist was occupied and could not free himself or herself, in a reasonable time, from another case that he or she might be looking after in another part of the hospital. I hope that that demonstrates that anaesthetic cover for the obstetric department in Daisy Hill Hospital is safe and sound.

Craigavon Area Hospital has a bigger labour ward. There is a dedicated anaesthetic service on the Craigavon site between 9.00 am and 5.00 pm, and those anaesthetists are available to administer epidurals, for planned Caesarean sections and for any emergencies that might arise during the eight hours of a normal working day. In the evening, there is a resident anaesthetist who is competent in obstetric anaesthesia and can carry out all normal procedures, look after any emergencies in the labour ward and provide obstetric cover for epidural analgesia for pain relief. That doctor also has a duty to cover the accident and emergency department and the general theatres. It is possible that, during the emergency period of on call, he or she could also be called to the labour ward.

To parallel the situation in Daisy Hill: if the response is not quick enough for the labour ward, we have a full range of rostered consultant anaesthetists who live within a reasonable distance of the hospital and can return within a reasonable time to provide safe cover for the labour ward. We continue to recruit consultant anaesthetists, so we are now in the position of having two consultant anaesthetists on call in Craigavon for three nights out of seven. We have further and deeper cover than we had in the past.

We have also tried to minimise the risk of the resident anaesthetist being occupied in the general theatre. We use rules that have been laid down for the past 12 to 15 years by the National Confidential Enquiry into Perioperative Deaths (NCEPOD), which has published a number of reports. Those reports indicate that, throughout the United Kingdom, cases that did not need to go to general theatres in the middle of the night should not be listed or permitted to go to theatres. That means that we are not undertaking unnecessary emergency work in general theatres, which leads to a higher likelihood of the resident anaesthetist being immediately available.

Through the implementation of NICE guidelines for the induction of labour, we have brought forward the time for induction. That means that the busy period when the anaesthetists are needed tends to be more concentrated during the day and the early evening. We have good deep double cover with a consultant and with a junior doctor on the Craigavon site.

We took a strong risk avoidance strategy to our anaesthetic cover, and we are in a position to say that anaesthetic cover on the Craigavon site, for all the above reasons, is good and safe.

Mr Francis Rice (Southern Health and Social Care Trust):

I will refer briefly to some of the issues with the midwifery workforce that were raised in the RQIA report. Initially in 2003, an audit of the midwifery workforce was carried out in the trusts using a nationally agreed tool — Birthrate Plus. It identified gaps in staffing levels. The commissioner worked with the trust to provide additional midwives at Craigavon Area Hospital and Daisy Hill Hospital. The increase in the number of midwives enables the midwifery-led unit to now deal with 900 births a year, as Mrs McAlinden mentioned. Additionality was also afforded to community midwifery services.

The trust faced specific challenges in relation to its midwifery workforce. We had to look to innovative measures to secure the funded establishment for the trust. Initially, we asked some

midwives who were working in the special care baby unit and general theatres to consider coming back to work in the midwifery service. A number of them did so, and we backfilled their posts with appropriately trained children's nurses or general acute nurses. We also asked for expressions of interest from nurses working in acute hospital services to train on an 18-month programme to become midwives. A further 12 individuals availed themselves of that programme. They now work in the service and live locally, and they are expected to remain with us.

Another initiative looked at the introduction of maternity support workers. We ran a 10-month intensive programme to train maternity support workers. Eight of those people now work in hospital and community services, and a further 11 will be employed in maternity services in June. They work in antenatal clinics and undertake physiological observations, obtain venous blood samples and help with breastfeeding and newborn babies to allow midwives to concentrate their clinical skills where they should be.

Mrs McAlinden:

If that evidence is sufficient, we are happy to take members' questions.

The Chairperson:

The advantage of giving evidence last at a Committee hearing is that you can head off some of the questions that were asked earlier. You certainly dealt head on with some of the issues that we intended to raise. Dr Loughran, you said that you are now fairly content with the level of anaesthetic cover at Daisy Hill and Craigavon. However, you made a number of bids for additional funding, which implies that you still think that there is room for improvement.

Dr Loughran:

Yes; I agree with that. We held discussions with the commissioner to try to get two rotas for non-consultants, resident in the Craigavon unit. Ultimately, we would like a dedicated obstetric anaesthetist in the house 24/7.

The Chairperson:

Have those bids delivered any outcomes?

Mrs McAlinden:

No; to be absolutely truthful, they have not. Discussions are ongoing, but there are many dependent factors. It would cost a significant amount of money to have a fully resident second rota in Craigavon Area Hospital. Depending on the availability of junior doctors, the cost could be anything between £300,000 and £750,000. Complicated discussions are ongoing with a number of parties, but we want to assure the Committee that we have made the situation as safe as we can at this point. The absolute gold standard of the RQIA report is to have two resident rotas in Craigavon Area Hospital, one of which is dedicated solely to the obstetric unit and ready and available to respond at any time.

The Chairperson:

You deal with large numbers of patients. Indeed, you are almost on a par with the Belfast Trust.

Mrs McAlinden:

We are the second-busiest unit in Northern Ireland.

The Chairperson:

That is extraordinary, given the difference in the populations of the two areas and the fact that the Belfast Trust deals with many complex cases on top of its normal load. Uniquely, you have also had a spike in maternity admissions from ethnic minorities and overseas populations. I was in Dungannon and Portadown recently, and I began to think that I was the only person in those towns who was born and bred in Northern Ireland. All that I could hear were Slovaks, Poles, Lithuanians, and so on. I assume that most of the migrant workers are of childbearing age. Has that caused any difficulties at Craigavon or Daisy Hill?

Dr Rankin:

It has certainly required the trust to make excellent use of its regional interpreting services, and it is important that we have access to appropriate languages. However, the increase in migrant workers has not had an impact on the Southern Trust's birth rates. The trust has taken the process on board and is happy with the diversity of mothers in its maternity units.

The Chairperson:

From a cultural point of view, are those mothers happy with the arrangements in Craigavon Area Hospital? Is there anything different in how births are handled in Moldova as opposed to

Magaherafelt?

Dr Rankin:

There will always be particular social mores that the trust must observe for people from particular ethnic minorities. The trust must do that when training its midwives, and it has done so.

The Chairperson:

Has the funding followed that trend? Has the Department of Health, Social Services and Public Safety (DHSSPS) and the Health and Social Care Board recognised the particulars? I assume that the trust handles the largest number of births from overseas workers in Northern Ireland.

Mrs McAlinden:

The trust has had an 8% increase in births, and you quite rightly pointed out that there is diversity within that increase, which presents certain challenges. However, the units are well able to address those challenges.

The trust received investment over the four-year period for two reasons: first, the population in the Southern Trust area is underfunded in terms of fair shares; and secondly, there is an ongoing capitation funding gap. Over the past three years, some money was made available to address that gap, and the then commissioner of the Southern Health and Social Services Board prioritised investment in maternity services. As a result of that investment, the trust was able to improve the midwifery-led unit in Craigavon Area Hospital by recruiting a further seven midwives, which allowed it to increase its capacity from 600 to 900 births a year. The trust used the available money to strengthen its maternity workforce and to address some of the pressures that the diversity of our mothers creates.

Mrs O'Neill:

Like the Chairperson, I feel that most issues have been covered at this stage. Has the RQIA's recommendation on the harmonisation of policies and guidance been an issue for the trust, or is it happy that that harmonisation has happened and that the information has been disseminated to all staff?

Dr Rankin:

The trust undertook a significant programme of harmonising its guidelines and procedures

through a strong multidisciplinary approach. It was not simply a desktop exercise, and all staff were engaged in the process. Over 40 of the trust's guidelines have been harmonised and made available to all staff on the trust intranet and in paper format, and are they available in each of the labour wards.

Mrs O'Neill:

What about creating a midwifery-led maternity unit in the South Tyrone Hospital? *[Laughter.]* Have I got away with asking that question?

The Chairperson:

Is that an RQIA recommendation? *[Laughter.]*

Mrs O'Neill:

The trust's maternity units are usually at full capacity. There has been investment, but the people of Tyrone would welcome the creation of a midwifery-led unit at the hospital. If money were not an issue, could the trust consider that, or is it unfair to ask you?

Mrs McAlinden:

I would tend towards the latter, Mrs O'Neill. *[Laughter.]* You are quite right, and when some of the changes were made at the South Tyrone Hospital, the creation of a midwifery-led unit was actively considered. The maternity unit at Craigavon Area Hospital is the second-busiest unit in Northern Ireland, and the unit at Daisy Hill Hospital is also busy with over 2,000 births each year. Therefore, if you are asking whether the review of maternity services to which Miriam McCarthy referred earlier should examine the potential hot spots for different types of maternity provision, I strongly hope that it does.

The Chairperson:

I will bring Sam Gardiner in, because the Southern Trust is in his constituency.

Mr Gardiner:

It is, and I have nothing bad to say about it. *[Laughter.]* I want to congratulate the trust and thank the witnesses for their presentation.

How many stillbirths are there each year in the Southern Trust area? Do you have those

figures?

Dr Rankin:

I do have them. In 2009, there were 25 stillbirths across the trust. The number of stillbirths takes into account foetuses that are aborted after 24 weeks right up to those stillborn at full term.

Mr Gardiner:

That is a quite a low level, and the trust seems to be getting good results from its deliveries. Again, congratulations all round.

Mrs McAlinden:

Mr Gardiner, you have hit on the mortality indicator, which is important for us. We quoted perinatal and neonatal mortality rates in our briefing paper, and Miriam McCarthy said that those outcomes were good when Northern Ireland is compared with the rest of the UK. Therefore, our mortality rates are good if that is an indicator of quality

The Chairperson:

Is there any indication that any of the more recent stillbirths were related to the problems with anaesthetic cover?

Dr Loughran:

Absolutely not. There is no connection between the stillbirths and any incident in relation to anaesthetic cover. The vast majority of stillbirths have no explanation. The confidential inquiry into stillbirths, which is carried out throughout the UK, states that between 55% and 75% of stillbirths have no apparent cause. In the two hospitals in the Southern Trust area, there is no connection between stillbirths and anaesthetic cover.

Mrs McAlinden:

It is fair to say that the Southern Trust is concerned that there was a specific recommendation on anaesthetic cover. We would not want to create any worry or concern in our local population about the safety of our services. From reading the RQIA report, members will be aware that it is not unusual to not have a resident anaesthetist on call who is available to the labour ward 24/7. We have carefully examined the level of risk. We considered how often the on-call anaesthetist comes in and how often the person who is resident in the hospital is required to do other duties

apart from those in the labour ward. We continue to manage that risk.

Mr Gardiner:

The recently opened trauma and orthopaedic centre at the hospital has state-of-the-art facilities, and I hope that the Committee will visit it. Not another hospital in the United Kingdom could match it. It is brilliant.

The Chairperson:

It must be the outstanding representatives for the area.

Mr McDevitt:

I am interested in the issue of anaesthetic cover. I appreciate that you want to reassure people about the consequences of the recommendations, but, by regional standards, you underperform. Dr Loughran, you seem to the only person today who is in favour of standard 4.6 as the appropriate benchmark against which to work.

Dr Loughran:

My background is in anaesthetics. I am a consultant anaesthetist, and it is only in the past couple of years that I have stopped performing anaesthetics. I worked in services that included maternity services, and throughout my anaesthetic career, I would have regarded maternity services — the labour ward — as the first port of call and as the most important part of the hospital to which an anaesthetist should be available, to keep an eye on, and ensure, that it was well and properly covered. Perhaps because of that background in anaesthetics, I regard the standard as acceptable. As a standard, it is certainly a counsel of perfection. When we cannot achieve that counsel of perfection, we must demonstrate that we take all due care and attention to ensure that the sole anaesthetist who is available to the labour ward is not occupied unnecessarily in any other duties except for lifesaving events.

The Chairperson:

Is it purely by chance that you are part of the delegation?

Dr Loughran:

There is only one medical director.

The Chairperson:

Who happens to be an expert in anaesthetics.

Dr Loughran:

Thank you.

Mr McDevitt:

It will be interesting to watch that situation. We were not able to get a direct answer from Dr McCarthy about whether that would be policy. She chose not to answer that question.

In 1989, a Professor Harley introduced NIMATS at the Royal Victoria Hospital. Why did it take 20 years to reach Craigavon Area Hospital?

Dr Rankin:

The Southern Trust is a new organisation, and we have a limited understanding of that. It appears that it had something to do with the IT infrastructure. All midwives need to have access to the system when they book women in because their details are entered onto the system. NIMATS has been around, but there were problems with funding and the availability of the IT infrastructure. However, Daisy Hill Hospital and the former Newry and Mourne Health and Social Services Trust took a different decision. In fact, NIMATS was implemented in Daisy Hill Hospital in the early 1990s.

Mr McDevitt:

My final point follows on from Mrs O'Neill's question, and I hope that she does not have a vested interest in it. It is to do with demographic mapping and the future planning of maternity services. A census is due in 2011. I know that you are not commissioners so I do not ask you to provide answers as such. However, as professionals, do you believe that the adequate tools are available locally or regionally to map demographic pressure points so that any conversation on the planning of maternity services results in those services being physically located where they are most needed?

Mrs McAlinden:

Fairly good demographic information is available. For example, when we were designing the improvements to the maternity unit at Craigavon Area Hospital, we made use of demographic

information to ensure that we were future proofing it. The information was provided to us by the commissioner, and, over a five-year period, it has been relatively accurate. Less accurate are the demographic figures on the impact of population shift and change, either within the island or relating to people coming in and out of the island. You are right to say that we should be conscious of future demographics, but it is questionable how accurate those predictions can be and can be made to be.

Dr Deeny:

The last time that I saw Dr Loughran was at the start of the 1980s when he was a registrar in anaesthetics. I worked at Daisy Hill Hospital from 1980 to 1986.

Dr Loughran:

I remember you very well.

Dr Deeny:

It is nice to see you again; that was a long time ago.

From my GP practice, I am aware that, because of what happened in Dungannon and Magherafelt, maternity patients from Cookstown now attend Craigavon Area Hospital. Is it the case, as has been suggested to me in recent years, that Craigavon is much busier? Twice in the past year or so, I have been told that the midwives are literally running from patient to patient at Craigavon. I was first told that by a lady who had had her fifth or sixth child at Craigavon. I have been told that midwives do not have time to speak to mothers because they are literally running from patient to patient. The two areas of Craigavon Area Hospital where patients say that staff are run off their feet are A&E and maternity services.

I have heard the comment, statement or, possibly, complaint from mothers that, after the baby is born, staff cannot wait to get them home again. I know that that is said about many hospitals nowadays. As a trust and as a health provider, are you concerned about early discharges? Those of us who work in primary care are concerned about early discharges, not only from maternity units but from other medical areas. Perhaps hospitals have sometimes gone overboard in sending people home too quickly. What is the usual time frame from admission to discharge in the case of a normal, uncomplicated delivery at Craigavon Area Hospital and at Daisy Hill Hospital?

Mrs McAlinden:

I shall answer the first part of your question, which was on the adequacy of our staffing levels in maternity services. Francis Rice has examined that issue carefully, and one reason why we carry out the Birthrate Plus exercise is to measure ourselves against benchmarks elsewhere. We have been assured and reassured that, in maternity services, our staffing level for midwifery is 1:28, which is the Birthrate Plus standard.

In the past, we had difficulty in recruiting midwives, and we have recruited significantly. Francis outlined the different initiatives that we used, and we are content that our midwifery staffing levels are much improved from 2003, when the first survey took place. It is a busy unit, and the pressures are increasing, but we have been able to enhance our midwifery staff and workforce on the back of investment that we received. We outlined some of that earlier. That is not to say that those staff are not very busy; having visited the unit recently, I know that they are.

Dr Rankin:

I shall answer the questions about length of stay and discharge policies. For many years, Craigavon Area Hospital has offered women and their families the opportunity to be discharged six hours after birth if they wish. That is not new to us, but there is no policy that requires that that should happen. We have a range of situations in which women can be discharged safely after six hours if they wish with the appropriate support of the community midwife. Nevertheless, if people seek to stay for 24 or 48 hours, that is also the norm. There is no requirement, and there is no bed pressure in that area of the service at all that requires women to be discharged at a particular time. I cannot quote the specific figures, but women have that choice.

Mrs McAlinden:

At times, however, the unit can be very busy.

Dr Deeny:

Therefore, it is not the case that a women feels that she is being moved out quickly because staff are waiting on her bed for another woman coming in?

Dr Rankin:

No, that is not the case. The post-natal ward is busy, but it is not that busy.

Dr Deeny:

Do you get feedback from patients?

Dr Rankin:

We do get feedback from patients. I was round the wards recently, talking to mothers, and I have no sense of that happening. However, given that you raised the matter, I am happy to consider it further.

Mrs McAlinden:

For an indicator of that scenario, we look at adverse incident reports — Dr Rankin demonstrated how we examine and deal with those — or an unusually high number of complaints. The number of complaints that we receive is just over 1% of the number of women who have their babies in our hospitals. It takes an enormous amount of courage and conviction for a mother to make a complaint when she has just been through delivery of services, but, comparatively speaking, our complaint rate is not high, and we do not receive a significant number of complaints indicating that people feel that they have been sent home too early. Mothers do complain, and rightly so. Some of the complaints are about our environment, and that is one of the reasons why we were able to secure the money to improve the facilities in Craigavon Area Hospital and Daisy Hill Hospital. There are some complaints about the attitude of our staff, and we take all those complaints seriously.

The Chairperson:

The survey results are a better indicator, because, as you say, there may be some inertia about writing in to complain. The survey results indicate that not much is wrong.

Mrs McAlinden:

The survey shows that 92% of women were either "completely" or "very" satisfied, and we are pleased about that.

The Chairperson:

This is the Committee's fourth evidence session today on the RQIA reports, so the issue of intrapartum care has been well examined.

Thank you very much for your information.