Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Group B Streptococcus:
Department of Health

14 September 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mrs Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Dr Stan Craig	)	Belfast Health and Social Care Trust
Dr Margaret Boyle	)	Department of Health, Social Services and Public Safety
Dr Elizabeth Mitchell	)	
Dr Paul Fogarty	)	South Eastern Health and Social Care Trust

The Chairperson:

I am pleased to welcome Dr Elizabeth Mitchell, the Department of Health, Social Services and Public Safety (DHSSPS) deputy chief medical officer; Dr Margaret Boyle, a senior medical officer in the Department; Dr Paul Fogarty, a consultant in obstetrics and gynaecology in the

South Eastern Health and Social Care Trust; and Dr Stan Craig, the consultant neonatologist in the Belfast Health and Social Care Trust. Stan does the same job as Alison, who gave evidence in the previous session.

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety):

I will begin by thanking the Committee for Health, Social Services and Public Safety for giving us this opportunity. I particularly want to thank Paul and Stan for coming today and taking time out of their busy clinical schedules. Their main reason for being here is to answer any questions that members may have about clinical practice in Northern Ireland relating to obstetrics or neonatology. As you heard, Stan collects data on behalf of all the neonatal intensive care units in Northern Ireland on the outcomes for all babies who go through neonatal intensive care. He has some figures on the incidence of group B streptococcus in Northern Ireland, which he will be able to talk about. He is speaking from a position of having collected some of that data.

The Chairperson:

Before we move on, Elizabeth, does that data relate to all babies affected by group B strep?

Dr Stan Craig (Belfast Health and Social Care Trust):

It is on all babies who have come through the neonatal intensive care units.

The Chairperson:

Stillborn babies do not come under that category.

Dr S Craig:

No.

The Chairperson:

It is good for members' clarification that we know that we are talking about live babies who have been through those units.

Dr Mitchell:

It is the babies who survive to go into the neonatal intensive care units.

As Jillian advised you, the Minister of Health, Social Services and Public Safety met a group

of families last Tuesday. He was very moved by their stories, as anyone would be. Kieran said that if we were compassionate, we would all feel for those families, and indeed we do. We are all starting from the same point, which is that we want to do the best for every baby who is born in Northern Ireland and for every pregnant mother in Northern Ireland. That is where we are all coming from, and it is why we went into medicine. We want to help people, and that is also where the Department and the Minister are coming from. We are all trying to work towards the same outcome. The issue is about finding the best way to achieve that.

As Janice said, there are two main approaches to reducing group B strep: screening in pregnancy and the identification of risk factors. As you have heard, the approach throughout the UK and in the Republic of Ireland is based on the identification of clinical risk factors. That policy is based on the advice of the UK National Screening Committee, which advises the four UK countries, the National Institute for Health and Clinical Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Those three organisations have examined the evidence on screening, and their current position is that it is not recommended.

In 2008, the Department endorsed a risk-based approach to group B strep when we issued NICE clinical guideline 62 for antenatal care. That covers the routine care that all women can expect to receive during pregnancy and refers health professionals to the RCOG guideline on the prevention of early-onset neonatal group B strep disease.

The guideline was produced following a robust review of the available evidence. It focuses on the identification of risk factors and advises healthcare professionals on the clinical assessment of individual women and the indications for offering antibiotics during labour. Between 60% and 70% of cases of early-onset group B strep are associated with those identifiable risk factors, and it is thought that the majority of severe cases could be prevented by targeting that group. The RCOG is reviewing and updating its guideline, which is due to be published in January 2012.

It is our intention to issue a letter from the Chief Medical Officer and the Chief Nursing Officer to relevant healthcare professionals to highlight the revised guidelines and to hold a seminar to help to raise awareness. That will help to update the professional knowledge, which, as we heard, is a key factor, and guide the identification and management of high-risk pregnancies.

The UK National Screening Committee's position is that, until it is clear that antenatal screening for group B strep does more good than harm, it does not recommend routine screening in the UK. As I mentioned, that is an expert body that advises the four UK Health Departments on all aspects of screening policy. It has kept the evidence on screening for group B strep infection under review and, following its most recent review in 2008, reaffirmed its 2003 advice. Again, that body is planning to review all the evidence, which will include international studies and evidence from all the countries that have screening as well as what is currently happening in the UK. It is planning to review that policy advice early in 2012.

We all recognise the fact that every screening programme has the potential to cause harm as well as to be beneficial. Therefore, when we introduce a screening programme, we must be sure that the evidence strongly shows that we are doing more good than harm. There are still a number of unanswered questions on the reliability of the test and the widespread use of antibiotics in labour. We can cover that issue when we take questions.

We recognise the fact that group B strep is the leading cause of serious neonatal infection in the UK. The previous witnesses gave information about the British Paediatric Surveillance Unit's 2001 study. That study, which covered a 13-month period, estimated that one in 2,000 babies in the UK and Ireland — you are right, it did include Ireland as well as the countries of the UK — developed early-onset group B strep infection. It identified 377 cases of early-onset group B strep, 39 of whom died. I will put that in context: in the UK in 2001, there were 2,107 neonatal deaths from all causes. In Northern Ireland, based on data from our laboratories and from neonatal intensive care outcomes research and evaluation (NICORE), we estimate that, on average, there are 12 babies a year with early-onset group B strep, which equates to about 0·4 or 0·5 per 1,000 live births.

The data on the incidence of early-onset group B strep in the UK is comparable with that found in countries such as the USA and Spain, which carry out screening. A recent Health Protection Agency report found that early-onset group B strep occurred in 0·37 per 1,000 live births in 2009. In the USA and Spain, the rate is about 0·35 per 1,000 live births.

One of the issues that we were asked to cover was the cost of treating babies with group B strep. That will clearly vary depending on the severity of the infection, on whether the infection was the only reason why a baby was admitted to neonatal intensive care and on whether a baby

suffered long-term consequences from the infection. At this point, we are not able to give an accurate costing for that. The average cost of treating a baby in hospital ranges from approximately £500 to £1,100 a day, depending on the level of care needed. However, as we heard, that clearly does not take into account babies who suffer long-term consequences from the infection. There have been no conclusive assessments for the cost of the screening strategy in the UK or Northern Ireland to date. Our current policy is based on that expert advice about the balance between harm and benefit and not on the potential costs of introducing such a programme. Indeed, I think that the Minister said that, for him, the issue is not about cost.

Studies have attempted to examine the cost-effectiveness of different approaches to reducing group B strep infection, including screening, treating those with risk factors and providing vaccination, if that were available. However, even researchers have emphasised that there is considerable uncertainty about their conclusions.

What has been happening to address group B strep in Northern Ireland and nationally? As I said, the UK National Screening Committee will review the evidence again in early 2012, and the RCOG will publish its revised guidelines on the prevention of early-onset group B strep in January 2012. So the Minister and departmental officials will want to consider the outcomes of those reviews when available.

In the interim, we have taken a number of steps. The Chief Medical Officer and the Chief Nursing Officer have written to healthcare professionals to highlight the clinical management of group B strep in pregnancy and to ensure that they are aware of the current guidelines and are following them appropriately. We have asked the Public Health Agency to take forward work to raise awareness of group B strep in pregnancy and to ensure that 'The Pregnancy Book' is updated so that it is clearer. We heard from Andy that there was some confusion about the text in the current book, so that will be updated early next year. We edit the book locally, at the Public Health Agency, so that we can produce a Northern Ireland edition. We also heard a lot about the lack of good information, and we concur that there are gaps in the information.

We have commissioned the Guidelines and Audit Implementation Network (GAIN) to undertake an audit of group B strep in Northern Ireland for us. We requested that the audit should focus on the obstetric aspects and the paediatric and neonatal perspective. I am very grateful to Paul and Stan, because I know that they have agreed to take part in and lead the audit,

which will be Northern Ireland-wide.

The Chief Medical Officer has written to Sir Harry Burns, the chair of the UK National Screening Committee, asking the committee to give the review of group B strep its earliest consideration and to examine specifically whether there are any issues with the incidence of the disease in Northern Ireland that would mean that we should be given special consideration, and offering to provide it with the data from the planned Northern Ireland audit.

The Chief Nursing Officer has written about group B strep to the providers of nurse education for all pre- and post-registration nursing students. There is an issue about the provision of information among healthcare professionals as well as among the public and parents-to-be. So we have asked for assurances on that.

I am pleased to report that the guidelines on antibiotics for early-onset neonatal infections, including group B strep, are due to be published by NICE in September 2012.

From my perspective, I believe that the development of a vaccine for group B strep would go some way towards providing an ideal solution. However, we know that that could be a minimum of five years away. Nevertheless, it would help to address early and late-onset and would, I think, get round many of the current issues.

Therefore, in conclusion, and to be clear: the Minister will consider in full the updated recommendations from the UK National Screening Committee and the Royal College of Obstetricians and Gynaecologists and their reviews of the evidence before making a final decision for Northern Ireland. My colleagues and I will be very happy to take any questions from members.

The Chairperson:

Thank you, Elizabeth. You are all very welcome. In the interests of fairness, it is important to have representatives from the Department to hear your perspective on the issue so that we get a balanced view. However, my opinion is that I have not heard anything today to convince me that we should not screen for group B strep at this stage. Is the Minister aware that the incidence of group B strep is higher in the North than it is in England and Wales and that that is unique?

Dr Mitchell:

The Minister has specially commissioned an additional audit to try to examine the information sources to make sure that they are complete, particularly for stillbirths. He has highlighted the fact that we need to look at that and provide an accurate reflection of the picture in Northern Ireland.

The Chairperson:

How long is that likely to take?

Dr Mitchell:

We have asked for the information to be produced by the end of February 2012 so that we can feed it into the UK National Screening Committee's work.

The Chairperson:

Why will it take so long?

Dr Mitchell:

I will defer to my colleagues on the work that is required for a detailed audit, which will also look at compliance with the guidelines, management of babies and their outcomes. That requires a significant amount of work and involves retrieving and going through notes and making a professional judgement of the information in them.

The Chairperson:

I want to give you a chance, but bear with me, if you do not mind, for a minute. As you know, we have three parents here today, who, within the past six months, have lost their little girl and their little boy to group B strep. I accept the fact that the figures that you quoted are quite low, but how many more babies will die before the Department breaks away from the guidance? I have been given guidance on a whole lot of things in the past, and it is up to you whether you accept recommendations. However, I have looked at the evidence and the research, and we have heard from the campaigners and you, but nothing convinces me that we should not do our own thing and make a decision now to try to ensure that Jillian and Andy and Sarah are not joined on that bench by another two, three, four or five families between now and six months' time in February.

I want to draw you out on the phrase "more good than harm" because we tried to ascertain that in the previous session. It is an interesting phrase, and we tried to draw it out of the health professionals who were witnesses in the previous session. We asked them about the side effects of giving intravenous antibiotics during labour, and we tried to tease out the issues around why you do not routinely test or act when a test proves that group B strep is in the gut and, therefore, is likely to cause complications. There is clear global evidence from places such as Slovenia, the Czech Republic, Kenya, Australia, Spain, France and Italy that it does more good than harm. Why are phrases such as that being used if there is no proof that it does more good than harm? Can you tease that out a bit for me?

Dr Mitchell:

We heard group B strep Support's perspective and interpretation of some of the worldwide data, but I think that the UK National Screening Committee will want to look at that evidence directly and to explore it in detail. I will ask my colleague Margaret Boyle to identify some of the issues that have been raised, which mean that this is not a straightforward decision that we can take immediately.

Dr Margaret Boyle (Department of Health, Social Services and Public Safety):

One of the issues being raised is the reliability of the test. The first papers on reliability came from America, then France and, more recently, Italy. They all found that over 60% of the babies who had group B strep were born to mothers who had been screened and were given a negative result. Therefore, there are questions around the test. Obviously, more work has to be done to find out the exact issues. Is it the fact that it is a particularly unreliable test? We heard some discussion earlier about the infection being transient and how it can be present now but may not be present in a few weeks' time. Is it that it was not present when mothers were screened at 35 to 37 weeks but that they were colonised before they gave birth? There are many unknowns.

There was a reference to the enriched culture medium (ECM) being the gold standard test. Last year, the Centers for Disease Control and Prevention (CDC) in Atlanta issued guidance in America about the test. There were quite stringent details about taking the test, its storage at a very low temperature, how it needed to be transported within 24 hours, and so forth. It also mentioned the fact that there were other tests that could be used. Therefore, there are issues with the test. Alison referred to the polymerase chain reaction (PCR) test, which could be done more as a rapid test, and there is further information needed on that.

There are concerns about the use of antibiotics, and I know that that was covered to some extent earlier. The allergic reaction — it was referred to as anaphylaxis — is an issue; it is a very unusual complication, but, sadly, it can result in the death of the mother. Even if the mother survives, often the baby does not. It is something that 25% of women carry. Therefore, you would be giving antibiotics to 25% of women, which, in Northern Ireland, equates to 6,000 or 7,000 women a year. There is the potential for increasing resistance to antibiotics, and there is evidence that, in America, the number of babies with group B strep has reduced, but the number of babies with E. coli, which is another type of infection, has increased. Stan may want to comment on that later.

By giving antibiotics to so many mothers in labour, babies are being exposed to antibiotics at a very vulnerable age, and we do not know the long-term impact of that. Jane referred to the Oracle study, which dealt with women in preterm labour. I am not saying that the two studies or the uses of antibiotics are comparable in any way. Nonetheless, that study showed that there was a significant increase in the number of babies born to those mothers who were given antibiotics who had cerebral palsy and other developmental abnormalities when they were examined at seven or eight years of age. There is still an unknown about the long-term, or possible long-term, risks of antibiotics. Those are some of the uncertainties. The UK National Screening Committee still —

The Chairperson:

May I interrupt you, Margaret? A lot of this is down to information. You talked about the reliability of the tests, but we heard earlier that that depended on the high vaginal swab not being as accurate as the lower swab or anorectal culture. Surely education with regard to getting the swab or the test, transportation, storage and all the rest can be done. In my view, that is not a barrier.

With regard to antibiotics being offered to women, I am a mother of three small children. I think, Elizabeth, that I was in a meeting with you and Bairbre de Brún when I was breastfeeding my first child a number of years ago. I was offered an amniocentesis, and I chose not to take it. Had I been offered a test for group B strep when I was pregnant with any of my three children and had had the risks explained to me, I would have jumped at the chance to have taken the test. If the test had been positive, and I had been offered antibiotics in labour, again, I would have

taken them. However, if I had been given the choice, at least I would have had a choice.

The difficulty for me — we have to weigh up the risks — was that when Emmet, my eldest, was a baby and he was getting the measles, mumps and rubella (MMR) injection, many of my friends decided that they would not take up the offer of the vaccination because of the risks associated with it, particularly given the links at that time with autism and Asperger's syndrome. When I was making that decision, I spoke to a range of people. One of the most sensible people to whom I spoke was my GP, who said nobody ever died of autism, but if anyone had seen a baby die of measles, he or she would never forget it. I had to weigh up the risks: I could, because it was not proven, give my child something that would harm his development, or I could not give it to him, and he could risk picking up measles, from which he could die. So I assessed the risk in that scenario based on information, and I chose for him to get the MMR injection. All three of my children got it. My friends' children did not get it, which was their choice. However, they had the choice.

There is an issue about whether or not to get the test and whether or not to get antibiotics, from which complications may arise. In the words of somebody who is not very far away, I would prefer to have a living baby with complications than a dead baby, and if I were asked the question a thousand times, I know what my answer would be every single time. So none of those is stacking up for me. I feel that too much emphasis is placed on NICE's clinical assessment and not enough on local evidence. We will hear from Stan and Paul later.

I could completely monopolise this evidence session, so I want to be fair to members. That is why I went a wee bit easy in the previous session. I did not allow Paula to ask questions in that session, which I do not often do. There is a queue of members; I am going to bump Paula to the top, and I will try to get everybody in. I could ask questions for three hours, and I am not the only one. We are five years away from the PCR vaccine. We should not be waiting on it. There are two tests now, one of which is more reliable. We should be looking at this in very clear terms.

Ms P Bradley:

Take a breath, Chair, and leave us some questions. I was ticking them off as you talked.

I will follow up on what the Chairperson said. Last year, we had the swine flu epidemic, when

we did not know the effects, and pregnant women were given one set of guidelines followed by a different set. Some people said yes you should, and others said no you should not. Even among my pregnant friends, their various GPs gave different advice because they did not know what the effects would be. Again, it was up to the mother, who should have the choice. Perhaps I have missed something somewhere along the road, but how long has research been going on into group B strep?

Dr Mitchell:

Where do I start? With respect to NICE, the UK National Screening Committee looked at the issue in 2003. I think that the RCOG guidelines were produced in 2003, which would have been based on the evidence available at that time. Things are kept under review, because evidence changes and builds up, and we can look at studies from other countries.

Ms P Bradley:

I know that many issues do not come through the Committee, and we cannot be expected to see everything. Earlier, Jim said that this is the first time that the Committee has heard of the issue and that it has not been brought to it before. I find it shameful that mothers and fathers have to come to us to give us the information. This has been going on for such a long time. I have had two children. I had vaccines when I was a teenager, and I underwent various tests when I was pregnant, yet here we have something else that has been in the research pipeline for such a long time, but we have no knowledge of it. Like everyone else sitting here, I have never heard of this before, and when I read the little bit in the book that people are given to read, I found it to be quite benign. There is nothing that would make people think that they must go and get that done. I find it really quite shameful that we had to rely on the people sitting here to come and give us this information. Something has to be done. We cannot sit on this. If we can save lives, we have to grasp the issue with both hands.

[Interruption.]

The Chairperson:

This session is being recorded, so whoever's mobile that is, would they mind turning it off? I know that it is embarrassing, but will you please switch it off completely or the recording equipment will not be able to pick up what is being said? I am looking around the room in general; it could be anybody. Will everybody double-check and make sure that their phones are

switched off.

Mr McCallister:

Thanks, Chair. You nearly stole all the questions. *[Laughter.]*

I want to raise several issues. The Chair mentioned the screening process. The previous group talked about the accuracy of screening as being about 90%, but Margaret indicated that it could be as low as 60%. Even if we accept that broad range, from a clinical perspective, is 60% accuracy not better than not knowing at all? At present, assessments are being made purely on some of the risk factors that you are considering. Unfortunately for families, some of those risk factors occur when they have had tragedy in a previous pregnancy. That is one of the difficulties. You would be much better screening and sorting out the issues that the Chair talked about and that Alison mentioned in her evidence.

I noted the phrase "more good than harm", because I was concerned as to how you would ever get to that point. If we are possibly five years away from getting a vaccine, would there not be an argument for going for this now, in the hope that we get the vaccine in five years' time? It seems to me that we are down to a divide in medical opinion. It will be interesting to hear from the others. Stan does the same job as Alison, but does he share her view on this issue, or is there a difference of opinion? I am quite happy to hear from you on those questions.

Dr Mitchell:

I will bring Paul in to talk about the risk-based approach, what it means and what happens. As I said, that approach is estimated to prevent 60% to 70% of early-onset cases. As Margaret highlighted, some of the research recently published in Italy, France and America shows that the screening programme is giving rather similar results to that. It may not be either/or. However, we need to wait for the evidence to be reviewed by the UK National Screening Committee and the RCOG, which are looking at the entirety of the evidence.

Dr Paul Fogarty (South Eastern Health and Social Care Trust):

Thank you very much for inviting me along. It might come as a surprise to you, but I cannot do an operation or a test to prescribe a drug unless it has been recommended. I practise evidence-based medicine. There has to be unbiased, not anecdotal, evidence. What we heard earlier was tragic, but it is personal. Those are stories, and we cannot base an entire road traffic management

policy on one car accident. We have to stand back and look as professionals. That is what we call evidence-based medicine.

Three organisations — NICE, the RCOG and the UK National Screening Committee — have all said the same. There is no grey area. It is not as though one of those organisations is saying yes and the others are saying no; all three are saying that screening is not working.

I will give you an example. Screening is a fishing net. I work in the Ulster Hospital, where 4,000 babies a year are born. So I have to throw out a net to find the two babies, not who will die, but who will have group B strep. I will have to test 4,000 women using rectal swabs. That involves another visit to the hospital for those women, who will all get antibiotics. That is not without its risks, because many women are allergic to penicillin and have to be given clindamycin. I do not expect you to know that drug, but it is a really nasty drug that can give people clostridium difficile. You have probably discussed clostridium difficile in this room. That is a side effect that you have to think about.

Unfortunately, the other side effect was evidenced in Mr Brady's constituency. There was a woman in Newry who died from anaphylaxis; so, it is one in 1·8 million. We all do the lottery, and, last night, somebody won £100 million; that was the chance they took, and they won it. However, the one in 1·8 million that happened did so in Newry, so we are very sensitive. Someone also mentioned swine flu: I have had two women die in the Ulster Hospital. It gets very sensitive.

Let us get away from percentages. If, for instance, there are 4,000 women, and I have to swab all of them in order to try to identify two cases, I will probably end up treating 2,000 mothers and babies during labour. Think of the time and energy of midwives, who, perhaps, would be distracted from doing other proven benefits. That gives you an idea of where we are and the difficulty with screening.

Another example is breast cancer screening. We thought that mammography was safe, so we X-rayed everybody. It is now showing unnecessary mastectomies and breast cancer caused by the X-rays. We are not actually reducing the risk of breast cancer. That gives you an example of a screening tool that has backfired. Cervical screening — doing smears — has worked. That is why the National Screening Committee has to go to unbiased evidence, not evidence from a

support group or from families. That evidence may be out in January 2012. It is not that we are not doing anything: we take this very seriously. I cannot stress enough how seriously we take it.

I look after lots of mums, and they have asked me about the test. I said that I wanted to test their babies, so I screen every baby. In the labour ward, the risk assessment is taken very seriously. We watch the mothers during labour and watch the babies for the first 24 hours afterwards. If they show any signs, Dr Craig takes over. It is not that we are not doing anything.

You said that you have not heard about group B strep. There are hundreds of diseases that you will not have heard about, and I do not expect you to know about them. I brought along a folder, which is an example of what people get when they book. This is a thin one, because there is nothing in it yet. We are swamping women with information about things such as clots in their legs and ectopic pregnancies. Some 1% of women will suffer an ectopic pregnancy, and a lot will die. We have to try to prioritise what we tell women, because you can only remember two or three things. You may have already forgotten what I told you a few minutes ago.

The Chairperson:

We have not. If you give us the information, we might at least be able to go and research it.

Dr Fogarty:

You said three hours, and I think it is going to take a lot longer than three hours, because it is not clear. It is not black and white. I want to get that across to you. It is very grey.

Mr McCallister:

Are you definite in that you do not see the test as being in any way a useful guide to you for narrowing things down to the two women? The worry that we get from listening to the evidence is that, in some cases, the baby will not get the chance to go to Stan Craig.

Dr Fogarty:

Exactly.

The Chairperson:

The lucky ones will get to Stan.

Dr Fogarty:

As you know, I have spoken on the BBC about that recently. Unfortunately, there are 125 stillbirths every year in Northern Ireland. It is not discussed. It is a very small proportion compared to the 26,000 mums. Lots of babies die due to other causes, and intrapartum antibiotics are not going to stop those deaths, because the mums arrive and there is no heartbeat. That has nothing to do with infection; often it is due to something else. We need to separate neonatal infection from stillbirths. They are very different. There may be a slight overlap, but they are not quite the same.

The Chairperson:

In fairness, Paul, I am aware of stillbirth as well, as are many people around the table. We have not confused group B strep infection and stillbirth. We recognise that there are other reasons why people might have a stillborn baby. I want to look at that as well and see what can be done to reduce those numbers. There is a very high rate of stillbirth, but we are not confused. We know exactly what we are talking about. We have taken evidence and have researched the issue. I am sorry to say this, but you are not convincing me that I should not be given the choice between getting screened or not. Perhaps I am just being cynical, but it will be interesting to hear what others around the table say. John, are you finished?

Mr McCallister:

I want to ask why our rates are 30% to 40% higher. Does Paul accept that figure?

Dr Fogarty:

The first thing that we do as professionals is get real information. I do not think that the information is good. It is very poor quality information at present. We have some information from a neonatal point of view, but I would like to get the antenatal information. I cannot get it.

The Chairperson:

It was said earlier that some states in the USA have higher incidence rates than others. Are there any socioeconomic factors that might account for that? You talk about information, but it is difficult to analyse information when we cannot get it or if it is confusing or contradictory. If rationalisation of the information is not happening, then you are not getting the information that you need.

Dr Fogarty:

I cannot answer that either. I hold my hands up; I am not an epidemiologist. I am an obstetrician who works in the labour ward in the Ulster Hospital next door. That is what I do. However, I would not want to move to American medicine. There, one is paid per item of work, so, therefore, one does lots and lots of tests. If you have a headache in Northern Ireland, you get tested; if you get one in America, you get a CT scan instantly. Is that good medicine? I do not think so, when one sees the number of X-rays that people get exposed to. It is not good medicine.

The Chairperson:

It might be, if you had a brain tumour —

Dr Fogarty:

That is where you need to be clinically informed and make a clinically informed choice. American medicine is not necessarily good medicine. Americans spend so much more money, but their rates are no better.

Mr Wells:

As I learned from two years in the Chair, the Chairperson always gets the best questions. That is exactly what has happened here, and it is the prerogative of the Chair.

We are hearing two radically opposing arguments. We have listened to the experts who have come over from the mainland, and they do not agree with you. It is not just about America: it is about Slovenia, France — and Kenya, of all places, where standards are much lower generally than they are here. The test detects 90% of people who have this infection. No one has yet told me how the test does more harm than good; there is no harm at all in the test. There is nothing you could say that is painful or harmful about the test. It has no side effects; it is just a simple test. Do you accept that? A woman's health is not caused any problems by taking the test. In 90% of the cases, she will then know that she has the infection and can choose whether to have antibiotics. At least she will have the choice. Is that heresy; is there something wrong there?

Dr Mitchell:

As Margaret described, if you look at the recently published evidence — from Italy, for example, where they have a screening programme — they are using the test but are not getting 90% identification of those babies. Margaret, would you repeat that?

Mr Wells:

Are you talking about the United States?

Dr Mitchell:

No.

Dr Margaret Boyle:

The research was first published in the States, where it was shown that 50% to 60% plus of the babies who had the infection were born to mothers who had been screened in pregnancy, and they had a negative result. In other words, the mother did not have group B strep; yet, when the baby was born, it had group B strep.

Mr Wells:

What is to be lost by that, even if you accept that statistic? It means the 40% to 50% of mothers tested positive, could make an informed decision and presumably lives were saved as a result of that situation having arisen.

Dr Mitchell:

What about the other 40% to 50%, who were told that they had a negative test? You have to think about that and about the whole population. From a population perspective, a screening test must do more good than harm.

Mr Wells:

But you are making the perfect the enemy of the good.

Dr Mitchell:

No we are not.

Mr Wells:

You are saying that because you cannot detect everyone infected, you should not save half the babies.

Dr Margaret Boyle:

If you start out to screen all women, you will pick up 25%, because that is the number who will have group B strep, or who will be colonised, and they will be managed with antibiotics during labour. However, of the babies born with group B strep, 60% will be born to mothers who were told falsely that they had nothing to worry about, that they did not have group B strep, and that therefore everything would be fine. There are concerns about that. You are putting in place a screening test that does not achieve what it set outs to achieve.

I have one other point about screening that has been acknowledged by America as well. American rates of group B strep came down significantly; the figure quoted was 80%. If you look at their rates in the early 1990s and compare them to what they are now, there has been a drop of around 80%. However, their rates were significantly higher than those in the UK.

The Chairperson:

You are talking about the figures at that time; current figures here are rising. We are getting closer to where America was when they introduced screening.

Dr Margaret Boyle:

The figures from Health Protection Agency show that in the UK, the rate in 2009 was 0·37. In 2008, it was 0·39. In America, it is 0·34. The other issue, which America has acknowledged, is that you will never successfully reduce to zero the number of babies who are born with the infection. That is not possible. Therefore, the Americans almost feel that they are at a stage now where they cannot go any lower. Their rate is not hugely below the UK's rate. If we bring in a screening programme, the next question will be this: how much will we achieve by bringing in that programme given that our rate is not much higher than that of the United States?

Dr Mitchell:

Also to be considered is the performance of the test in practice across a range of women. If it was a perfect test, Jim, I do not think that any of us would be in dispute with you.

Mr Wells:

Women could be told that it is not a perfect test. They could be told that it may or may not show that they have an infection. At least those who had the infection and would be fortunate to have their tests prove positive would get treatment, and their babies' lives would be saved. It would

still mean that you would have a smaller number of women who would be very disappointed and angry, perhaps, that the test did not show up the infection. However, at least, you would have saved some lives by doing it —

Dr Fogarty:

I am sorry to interrupt. We need to have evidence for that. We are back to where we were when I came in — evidence-based medicine. We, in this Chamber, do not have the evidence to make that decision.

Mr Wells:

The cautionary principle says that until you have hard evidence, and while you are gathering new evidence, you should test and treat. You already know enough about this issue to do the test and follow the consequences of what can then be done if someone is proven to have the infection.

Dr Fogarty:

Jim, as Margaret has just said to you, all that testing has done in America is to bring their figures down to where we are now. There is no evidence to suggest that our rate will get any lower if we do what America has done.

Mr Wells:

Are you saying that no babies' lives would be saved if you went down that route?

Dr Fogarty:

We do not know. Let us get the evidence.

Mr Wells:

Why wait for the evidence when it is quite clear to me that you could act now and save some babies' lives immediately?

Dr Mitchell:

In order to introduce a population-based screening programme, we need that evidence. It is different from acting on information that has been provided to an individual. When we do something, we have to think about what the unforeseen consequences of that might be. That is what we are saying. We want to wait for review of the evidence by the experts. We are talking

about people who have a great deal more expertise on these issues than any of us in this room. We want them to look comprehensively at evidence worldwide and in the UK, and to make a recommendation. They are talking about doing that early in 2012. We are saying that we need to wait and see the evidence when they review it and what recommendations they make.

The Chairperson:

For clarification, Elizabeth, do you mean the randomised controlled trial about which the experts talked?

Dr Mitchell:

They will look at whatever published research evidence exists, gather information that is published through surveillance, and liaise with colleagues around the world where screening programmes have been introduced for any additional information available. They have access to information that we, in the Department, do not. Therefore, we need to wait for them to look at it. We are saying that the matter is complex and that there is a range of issues. We have to ensure that what we do by introducing screening does not make matters worse for some individuals. That is what we are saying, Jim. We just want to be sure that what we introduce, or recommend to the Minister and on which he must make a decision, will be the right decision for people in Northern Ireland. We want to look at the information base here. We want to provide the best information that we can on local cases so that that can be fed into the debate. That will, certainly, be part of what we will ask them do look at.

Mr Wells:

Would any of this have been done had Mrs Boyd not appeared on 'Talkback'?

Dr Mitchell:

Yes, the National Screening Committee reviews the evidence regularly. It had programmed that review anyway. The RCOG had already programmed its review of clinical guidelines. Therefore, those things would be happening anyway. We appreciate the initiative that the families have taken. They have highlighted issues that are very important. They have highlighted gaps. We will address those gaps. There is no doubt that there are issues with regard to information provided to pregnant women. We need to look at that. We will ask the Public Health Agency to look at that and see whether we need to develop local materials in addition to what is being provided already through the RCOG and group B strep Support on their websites.

We will take that on board. We all owe a debt of gratitude to the families for their bravery in highlighting the issue, and I echo what has been said about that. The clinicians have been aware of the issue and have been dealing with it for many years; it has not come to them out of the blue as a surprise.

Mr McCarthy:

I will be brief, because we are going over the same thing. Why has this taken so long? I have documentation stating that group B strep Support was founded across the water in 1996. I also have a paper stating that, on 5 February 2009, a new petition was launched in Northern Ireland calling for information and that testing for group B strep should be offered on the NHS to all pregnant women. We are hearing that you hope that some report will come in 2012. Meanwhile, babies' lives have been lost and will continue to be lost. Why has it taken so long? It seems to me that the recent outcry from the unfortunate parents who are in the Public Gallery has prompted you to move forward, albeit slowly. I cannot understand why we will have to wait until 2012, which is another six months away. There does not seem to be any urgency to get on top of the matter to prevent babies' lives from being lost.

I am glad that Elizabeth has said that you have instructed the Public Health Agency to get on top on the matter. It does not take much to issue a lot of leaflets to the public. Why can that not be done immediately? There seems to be a lack of urgency in all of this, and people's lives are being shattered because of it.

Dr Mitchell:

Thank you, Kieran. In producing such a leaflet, we need to ensure that it contains the right information and that it is sensitive to the issues that are relevant to families. We need to test and ensure that the information that we provide is correct. It is a matter of considering the evidence base for the information that we put in such a leaflet and the training requirements for staff. There are a lot of issues to consider. Even if we were to make a decision today, I am sure that it would take significant time to implement this in practice.

We hear what you are saying. The National Screening Committee has a programme in which it regularly reviews information on a range of different issues where there are calls for screening programmes. It also reviews existing screening programmes. The committee will be asked that

this be looked at as a priority. People are reviewing it. The RCOG has done this as a planned review. Again, it needs to ensure that there is sufficient new evidence available to make doing a review worthwhile. We are looking at all of those issues.

Mr McCarthy:

I hear what you are saying. In February 2009, a petition was launched. I cannot remember that because I was not a member of the Committee at that time. Two years have passed since then, and the leaflet has still not been produced. Making valuable information available would be a very minor start in what we should be doing. You heard the presentations from the people who have suffered. I implore you to consider that the least you can do is to get on with it, even by producing a leaflet that will inform future pregnant mothers so that they will not go through the same situation as the parents from whom we heard this afternoon.

Mr Durkan:

I share the frustration of my colleagues on the apparent slowness of progress on the issue. However, it is worth acknowledging that the review has been commissioned and that that is a step in the right direction, albeit not as large a step as we would like at this stage.

The panel were citing American statistics on the one hand and dismissing them on the other as it suited. Mention was also made of the new group B strep guidelines for health professionals, and Kieran touched on health promotion. When will the guidelines be introduced, and how will they be monitored?

Dr Mitchell:

We are referring to existing guidelines published by the RCOG in 2003. As Paul said earlier, those are the guidelines currently being used by obstetricians and midwives on a daily basis across trusts in Northern Ireland. They are being revised and updated, and we expect them to be available in January. It is not a case of us starting from nothing, or that nothing has been done about this infection for many years. Action has been taken based on the current guidelines, which are a risk-based approach.

The Chairperson:

It may be helpful at this stage if we brought in Stan Craig, if you are OK with that, Stan. It might add to the discussion if you were to give us some of your thoughts. Given that you do the same

job as Alison Bedford-Russell, it would be interesting to hear your perspective.

Dr S Craig:

I am relatively new to these sorts of scenarios. I apologise for laughing, but for the first time ever I am glad that I am a paediatrician, or neonatologist, rather than a public health doctor. Sometimes, when you are up in the intensive care unit at 1.00 am you think to yourself: "Why didn't I do public health?"

When I was asked to find out some information about group B strep, I turned to my own experience in the Royal Maternity Hospital and tried to get information from the maternity data systems. As I said in my emails to Janice Thompson, your researcher, it is difficult to get information from those. So, over the past couple of weeks, I have been pulling charts myself to try to get some sort of figures. From the paediatric perspective, those figures can be very small because of the individual numbers involved and individual clinicians' experience in the intensive care unit. So, it is very difficult for me, as an intensive care paediatrician, to get the full picture.

What I shared with Janice was some of the data I was able to get from the NICORE database for 2009, which was the first year that we collected data on specific organisms that cause infection. To give you guys some understanding of how we collect the data, NICORE stands for the neonatal intensive care outcomes, research and evaluation group, which is a fancy phrase for the neonatal audit data collection group, which I happen to chair.

For 2009, we identified 10 patients with early-onset group B strep. I have no doubt that some of the families of those patients would be part of the Group B Strep Support group. Nine would have delivered beyond the 35-week gestation group and would be into the gestational age when screening may or may not take place, and one was in the extreme pre-term group. Of those nine infants, two unfortunately died.

That is the best information that I have from the neonatal intensive care audit group. Alison Bedford-Russell mentioned babies who were treated as probable sepsis. Those babies had the various signs but did not have positive blood cultures, and there were an additional three infants in that group, two of whom were born after term.

My contribution is to try to quantify the burden of disease in my patch of medicine and to

make that information available. To put those numbers in context, approximately 1,800 infants were admitted to the intensive care units from which data is collected. Of that total, one or two infants can make the difference in percentage terms, because the 0·45 or the 0·34 per 1,000 live births that are affected by group B strep equates to two or three infants in our population. Obviously they are very important, but those are the sorts of figures that we see in the neonatal intensive care unit population. We do not see the late-onset group B strep population, because they often present after mums and babies have gone home. Although I have some information on the late-onset cases, there is no way that that represents the full picture. My figures represent pre-term babies who are already in the neonatal intensive care unit and happen to be getting treatment for group B strep because they have not gone home yet and are presenting within that time frame.

As a clinician, I am frustrated by the lack of availability of data. For an individual clinician the number of affected babies is relevantly small, so it is difficult to have a view of the big picture. I do not pretend to be an epidemiologist or an expert on whether screening and so forth is the best way forward. If I am being totally honest, anything that takes away the burden of disease from my patients — the babies — is to be welcomed. How that is best done is not something that I would be qualified to judge. I have tried to give as clear a summary of anonymised data as I can, and I forwarded that to Janice, who presented earlier.

Mr McCallister:

What can be done to improve that data? Are there steps that the Department and the trusts could take to improve the data collection and its quality? Paul talked about the need for it to be evidence-based, and I am quite sure that he would be happy to respond to the evidence if it were shown to him, but how do you improve the evidence? I understand that you are dealing with different conditions and complex problems and that it is not always clear-cut what a baby has. How do we improve the data?

Dr S Craig:

The data is there; the problem is the timeliness with which you can get the information. The data that I summarised for your researcher was collected by hand. Having systems and mechanisms in place that could link laboratory information, the data from my area of neonatal intensive care and data from the huge minefield that is antenatal care would be ideal.

Mr McCallister:

Some of that data could be vital.

The Chairperson:

It could be vital in providing the evidence base that Paul believes is not there.

Mr McCallister:

It may be important when decisions are made at national level. I am not saying that it could swing things one way or the other, but the more information there is and the more accurate the data, the better.

Dr S Craig:

I speak only for a small specialty, and I can only answer for what I see within it, but we are trying to implement an electronic data collection system similar to that which Alison Bedford-Russell described. That is being rolled out this year. I do not have any experience of trying to get data back out of it; I am building up experience of putting data into it. That may be a way of getting more timely information. As you have heard, I have spent the past two or three weeks on that, but I am getting only the 2009 data, which is clearly a couple of years out of date. From my perspective, it would be better if there were more timely information.

Dr Fogarty:

You are shaking your head, Chairperson, and it is shocking that, in the twenty-first century, Dr Craig has to pull that data out by hand. I chaired the review of Northern Ireland's maternity strategy, the report of which is about to be released by the Minister. One of the key elements of that is that we have to sort out our IT systems so that we at least have data on caesarean sections, neonatal issues and infections. Northern Ireland has a small population and we should be able to sort that out. I welcome any support that the Committee can give me to sort out Northern Ireland's maternity systems. We should have the data on the 26,000 deliveries that take place and be able to get information within six days rather than six months.

Mr McCallister:

Government does not have a great reputation for IT projects.

Dr Fogarty:

I know; that is my frustration.

The Chairperson:

One of the things that we need to address is proper technology for midwives and community health visitors so that they can input that information in a way that does not damage data protection and client confidentiality but that will allow it to be analysed.

Dr Fogarty:

I have very close relationships with midwives and, to be fair to them, they input the data terribly well. However, it gets lost in the database.

The Chairperson:

They also input it at 11.00 pm at home.

Dr Fogarty:

I do not know about that.

The Chairperson:

They do. They visit your home and fill out your red book to try to keep your data up to date. They could be putting that into a computer there and then using a handheld device or a laptop so that it is stored properly. Instead, they go home and do that at night. It is a really difficult situation for community midwives and district nurses.

Mr Dunne:

Most of the issues have been well covered. However, there is something that I talked about last night with my wife. We have three children, and she mentioned Dr Fogarty's name, because he was her consultant in the Ulster Hospital when a very healthy Amy was born 10 years ago. As I see it, you are trying to manage the present situation by managing the risk. We need assurances that the risk is being managed well. That is vital. The fact that it is so difficult to get data, as Paul said, may weaken that assurance in some ways. Perhaps someone could summarise how that risk is being managed. Obviously, patients who are identified as at risk are tested and screened.

Dr Mitchell:

I will let Dr Fogarty tell you what the current practice is when it comes to clinical risk-based assessment.

Dr Fogarty:

I delivered 12 patients on Monday in the labour ward. That is where I work; that is my Committee table on a Monday. If we had rectally swabbed those 12 patients, one third would have tested positive, one third would have been given antibiotics and the babies would probably have been fine. We do not look to see whether expectant mothers have a positive or negative result; we look at them for risk factors. In the Ulster Hospital, we have a tick sheet on which we tick all the risk factors. If they are at risk, they get antibiotics. It is not the mum who needs antibiotics; the antibiotics go across the placenta and start treating the baby before it gets to Stan.

Going back to what Jim said about it being just a test, the consequences of the test are fascinating. The mum takes intravenous antibiotics, but, if that is not done in time, the baby has to take them for up to five days. Therefore, you have a mum who wants to get home, with a perfectly well baby getting antibiotics through a cannula in its head or arm. In the Northern Ireland maternity strategy, we pushed demedicalising; that is, letting normal women have normal deliveries and get home with a healthy baby. If we start screening and suddenly find that one third of our women have positive swabs, they cannot go to midwifery units, they cannot go to the home from home, and they cannot have water births.

There is a knock-on effect from the simple test. That is why I am saying that we must be careful and we must have evidence. Primum non nocere: first, do no harm. I would hate to lose the lovely normal deliveries that we have in our home from home because a mother had a positive swab, when that mother and baby are well. To answer the question, we risk assess at the time. If they show risk, we do not hesitate to give antibiotics. I want to do the best for our mothers and babies, and I am glad that we are doing well 10 years on.

Mr Dunne:

You are doing very well.

Mr Brady:

Maybe I am taking a simplistic approach, but my understanding is that, ultimately, people are

screened and have tests done to prevent damage to the baby or so that a baby may not die from group B strep or whatever. Paul, you mentioned ectopic pregnancies. Is it possible to prevent an ectopic pregnancy?

Dr Fogarty:

Good question. The answer is no, but early detection means that it can be treated before it bursts.

Mr Brady:

I have had experience of an ectopic pregnancy; not personally, obviously. It sometimes presents too late and, as you said, can be fatal.

Dr Fogarty:

That is why we want to educate women that, if they have any pain or bleeding, we need to see them.

Mr Brady:

I understand that, but it may not be preventable. The death of a baby from group B strep can be prevented.

Dr Fogarty:

Not always.

Mr Brady:

Maybe not always, but it is more likely, shall we say. Surely that is the whole point of the test and giving —

Dr Fogarty:

We do not have the evidence to prove that.

Mr Brady:

I take your point about needing an evidence base, but surely we are here to prevent the death of even one baby. You mentioned anaphylactic shock, and, tragically, a person in Newry died from that. It is about weighing up the risks and looking at the statistics. From the evidence that we heard from the previous group, it seems to me that screening makes the risk of babies dying from

group B strep much lower. Obviously, you need evidence-based medicine. Otherwise, you could not progress and do your job every day. However, my point is that this is a preventative type of medicine, and we should use it if it is possible to prevent even one death. You can educate people about ectopic pregnancies, but it will not necessarily prevent them.

Dr Fogarty:

It goes back to the difference between a screening test and a diagnostic test. We must remember that this is screening of a normal, low-risk population. If you are high risk, you get your antibiotics; that is very clear. What is very important about evidence-based medicine is evidence. With the greatest respect to my colleagues who were here, Professor Steer, etc, they are not unbiased; they came here as a support group. I have no axe to grind; I will do whatever the evidence tells me to do.

Mr Brady:

With respect, do we know any human beings who do not have a bias one way or the other?

Dr Fogarty:

That is why we have to go to the National Screening Committee and the RCOG, where the data is gone through with the greatest rigour.

Mr Brady:

A lot of those groups are expert, but, with respect, they very rarely put their hands up and say, "We may be wrong. We may have made a mistake." Therein lies the problem with some of those groups. Over a number of years, NICE has had its critics about certain types of drugs. Hopefully I am wrong, but I am quite convinced that, if a cure for cancer were found in the morning, there would be a waiting list for three or four years. We are dealing with a situation where the death of a baby can be prevented. That is possible, but there are other areas of medicine where it is not. We should be looking at the glass as being half full rather than half empty. With respect, experts tend to look at it as being half empty. Ultimately, the health service is based on cost.

Dr Fogarty:

I have not mentioned cost, and the Minister has reassured us that cost is not the issue. It has nothing to do with money.

Mr Brady:

I am delighted to hear that.

Dr Fogarty:

We are professionals; I work at the Royal College of Obstetricians and Gynaecologists on Thursdays and Fridays. We are a very professional body. The Royal College of Midwives is involved. Every three years, we review the statistics on the topic, because we know that it changes. It was due to be reviewed, and it is now at drafting stage. It has been out for consultation, and I know that Philip Steer and the group have already given input to the RCOG's most recent recommendations. The position is always changing.

The Chairperson:

With the greatest respect, Paul, you keeping talking about this being evidence-based, but, if you are not looking for the evidence, you cannot make an assessment on it. If you do not have evidence from the randomised control trials that have been proposed, you cannot make a decision. I want to leave the team with one thought: if you are private, you are screened.

Dr Fogarty:

You are not.

The Chairperson:

Are you absolutely sure about that? We will seek clarification from the Department on that.

Dr Fogarty:

I would like to take the opportunity to inform you about that, because there is a misconception about private obstetricians and gynaecologists. I have a large private practice, and I work hard. I have never screened a woman in 20 years. A woman can buy a kit for £32 from Amazon, but it states on that kit that the test must be done by a professional. You cannot do a rectal swab on yourself very easily. I have a midwife who has done two swabs in six months for no profit. That is down to personal choice. If a woman is worried enough to have bought a test, I will at least facilitate that with my private antenatal patients. I know of two others. There are probably only 12 obstetricians who do private obstetrics out of the 65 obstetricians in Northern Ireland, and they should be adhering to the RCOG guidelines. The situation is no different in private practice.

The Chairperson:

It might be worth asking the 12 of them.

Dr Fogarty:

I am happy to do that. But, again, it comes down to the matter of getting data.

The Chairperson:

Let us see what happens. You have nearly answered my next question. If the private test is done and comes back positive, will the woman be offered antibiotics in labour?

Dr Fogarty:

Yes.

The Chairperson:

I come at this from the point of view of having had three happy and healthy deliveries by midwives. My third was a water birth, and I am very much in favour of natural birth. However, I would not have had my water birth with Aoise if there had been any complications with that pregnancy. I know that if I had been told that any of my babies had passed away and that I was going to have to deliver the baby, I would have been given all the care and sympathy that a family gets when that happens. However, if that can be avoided, we have to do everything that we can to avoid it.

If I had been one of the parents who had done the test and received a positive result, I would have been offered antibiotics and I would have known that a water birth was out of the question. In that situation, I would have much preferred to have had an IV drip in my arm. My second child was induced and I had a drip on for him, so I know what that is like. If I had been told that I needed to be on antibiotics during labour for my baby to be delivered safely, I would have jumped at the chance.

That brings me back to the point that Dr Mitchell made about antibiotics. If women get the test privately and are screened, they get the antibiotics. Why, then, would you be so reluctant to do a screening programme and give the antibiotics? The exact same clinical procedure would take place regardless of whether a woman bought the test herself or if you did what we are asking

you to and introduced a screening programme. You spent a considerable amount of time on that issue earlier. However, I did not come in on it at that point, because I wanted to let other members in. They accused me of taking all the best questions, so I waited to see who would come up with this question. The pathway that you would take with a family with a positive test is exactly the same as the one that we are asking the Department to take now. You said that it does not work or that there are all sort of complications and reasons for not doing it. However, that is what you would do if somebody spent £32 getting tested and the test came back positive. Why is that?

Dr Mitchell:

I said that we are waiting on the review of all the evidence by the National Screening Committee; I did not say that a final decision has been made. I said that we are waiting on the committee to look at and review all the evidence, and I stand by that. That is what we are looking for. We will be guided by the advice that it gives us. The Minister will look at that in the context of other information that is available, including whatever local evidence we have, and he will make a decision. A decision has not been made at this point. We are awaiting that review of the evidence.

The Chairperson:

Again, it comes back to the point that if you do not have adequate evidence, you cannot make a decision.

Dr Mitchell:

But the evidence will reflect what is in all the publications and studies that have been done in other countries where there is screening. That is the evidence that what we are talking about. All of the evidence about the reliability of the test and the impact of the antibiotics will be taken in the round and examined critically by people with a great deal of expertise in looking at such issues. That is what we are waiting for. We want to make sure that our policy decision is the best decision and results in the best outcome.

As I said at the beginning, we all have the same goal, which is to prevent preventable infections in babies. That is where we are all coming from. What we are saying is that there is not universal agreement on the best way of achieving that. We, therefore, need to wait for the experts to look at it again and provide us with advice on that.

The Chairperson:

I do not like hypothetical situations, but say NICE comes back with a recommendation that, if the rate of positive group B strep tests here is above a threshold of, for argument's sake, 0·4 per 1,000 births, or whatever figure it comes up, screening will be done. If the number of positive tests in England and Wales is below that threshold but the number here is above it, what would happen?

Dr Mitchell:

We will look at its recommendations and decide what is best for Northern Ireland. We will base that on the evidence review that it has done.

Mr Wells:

Are we tied to England and Wales, or can we go on our own if we want?

Dr Mitchell:

The Minister can make that decision. He would want to be advised that he has made the best decision for the population of Northern Ireland. We would look carefully at who had examined that evidence and made those recommendations. If three national bodies with a great deal of expertise advised him that that was not the way to do it, I think that he would consider that carefully, as you would wish to do, were you Minister, Jim. *[Laughter.]*

The Chairperson:

I accept that this has been a long session. We will look at the Hansard report of today's meeting. I do not think that the issue is going to go away, Elizabeth; we will continue to press you on it. I have been very impressed by the level and depth of members' knowledge on the issue, which is, in no small part, down to the inspirational work of Jillian and Andy and the other parents — including Sarah, who is here too — who have helped to us to understand that one baby dying unnecessarily is one too many. That is the message that we want to get across to the Minister. Hopefully, you can report back to him on the kind of session that you had. I knew that it was always going to be difficult. I hope that you did not feel at any time that you were being intimidated or that we were being too hostile. We felt that there were a lot of things that we had to focus your mind on. I will read over the Hansard report. You still have not convinced me, so you will have to try harder next time.

Dr Mitchell:

When we have the outcome of the review by the National Screening Committee, we will be able to have another discussion.

The Chairperson:

Thank you all very much for your patience.