DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 21 Feabhra 2018

Wednesday, 21 February 2018

Tháinig an Comhchoiste le chéile ag 9 a.m.

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Bernard J. Durkan,	Colm Burke.
Billy Kelleher,	
Alan Kelly,	
Margaret Murphy O'Mahony,	
Kate O'Connell,	
Louise O'Reilly.	

Teachta / Deputy Michael Harty sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: I propose that we deal with housekeeping matters in private session. Is that agreed? Agreed.

The joint committee went into private session at 9.10 a.m. and resumed in public session at 9.20 a.m.

Review of National Maternity Strategy 2016-2026: Discussion

Chairman: The purpose of the meeting is to review the National Maternity Strategy 2016-2026 with the national programme director for the national women and infants' health programme of the HSE, the Institute of Obstetricians and Gynaecologists and the Irish Nurses and Midwives Organisation, INMO. On behalf of the committee I welcome Mr. Kilian McGrane, national programme director; Ms Angela Dunne and Dr. Peter McKenna of the national women and infants' health programme; Dr. Peter Boylan of the Institute of Obstetricians and Gynaecologists; and Ms Mary O'Gorman, Ms Mary Leahy and Ms Phil Ní Sheaghdha of the INMO.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of the evidence they are to give to the joint committee. If, however, they are directed by it to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. I also wish to advise the witnesses that the opening statements they have submitted to the committee may be published on the committee's website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

I invite Mr. Kilian McGrane to make his opening statement.

Mr. Kilian McGrane: I thank the committee for the invitation to attend the meeting. I am joined by my colleagues, Ms Angela Dunne, director of midwifery, and Dr. Peter McKenna, the clinical director.

The national women and infants' health programme was established in January 2017. The programme has responsibility for maternity services, benign gynaecology and neonatology. The focus in 2017 was on building relationships around the 19 maternity hospitals, working with the hospital groups to establish maternity networks and developing an implementation plan for the national maternity strategy. The implementation plan was completed in the summer of 2017 and launched by the Minister for Health in October 2017. The plan has over 230

specific actions designed to achieve the four strategic priorities of the strategy and specifically to address the 77 recommendations in the strategy. The programme has identified three priorities areas within the 230 actions for attention in 2018. These are anomaly scanning, the model of care and quality and safety. The programme was allocated €4.55 million in development funding for 2018 to address the actions in the implementation plan and that funding is being targeted in the following areas.

With regard to anomaly scanning, each hospital group has been asked to identify how many additional ultra-sonographers are required to ensure that 100% of women presenting at each maternity unit can be offered an anomaly scan. Hospital groups are being allocated funding in line with their requirements. In addition, the programme is working with the maternity networks to ensure foetal medicine expertise is available to support ultra-sonographers when an anomaly is identified. Given the challenges with recruitment and training, it is likely to be at least 18 months before we can achieve 100% access, but the 2018 investment will make tangible improvements.

The model of care is about providing women with informed choice regarding the care pathway they choose for their pregnancy. The specialised and assisted models are well established, and the programme is focusing on implementing the supported care pathway. In 2018, 52 additional midwives have been approved to support the further roll-out of the supported care pathway and to start the process of providing women with improved access to ante-natal and post-natal care closer to their homes. The programme acknowledges that there will be challenges with recruitment, but implementing the model of care will provide midwives will greater choice about how they can best practise their profession.

The programme recognises that while we develop the model of care and increase access for women to the supported care pathway, we also must build public confidence in our maternity services. How we deal with adverse incidents is critical to maintaining the trust and confidence of the general public and, in turn, will encourage women to access the supported care pathway. The programme has provided each maternity network with funding to support a quality and safety manager for women and infants. These posts will be central to the establishment within each network of a women and infants only serious incident management forum. The forum will ensure that all incidents for all maternity hospitals within the network are reviewed by a multidisciplinary team, which includes midwives, obstetricians, neonatologists, anaesthetists and risk management. This level of scrutiny and support will ensure units do not review incidents in isolation. The programme has also developed a draft incident management framework for maternity services. This process, which is aligned to the development of the serious incident management forum, will focus on a small number of very severe adverse events and seek to ensure that a similar methodology is used in investigating and reporting on these events. By focusing on the more extreme events in a systematic manner we aim to reduce the occurrence of these events through improved quality, better reviews and sharing of learning.

I will outline how the €4.55 million allocated in budget 2018 is being used. We will fund nine additional obstetrician-gynaecologist posts. We have engaged with the hospital groups to identify the areas of need and we hope this is the first step in adding the additional 100 posts identified by the Institute of Obstetricians and Gynaecologists and the HSE's clinical care programme. We also aim to fund three perinatal pathologists as part of that process. We have approved the appointment of an additional 28 ultra-sonographers to support access to anomaly scanning. In addition to the 52 registered midwives for the model of care, we have approved an additional 15 clinical midwife specialists in mental health, to align with the specialist model

launched in November 2017. We have allocated 12 health and social care professionals to support the health and well-being approach to maternity services and to address identified need within the system. We acknowledge that outside of the large centres the availability of health and social care professionals is quite limited. We have also allocated resources to each hospital group to establish their maternity networks, and a small amount of resource to support the phase one sites that are live on the maternal newborn clinical management system. In total, the €4.55 million will support approximately 150 additional whole-time equivalents.

Finally, the programme acknowledges the importance of having a dedicated unit to focus on women and infants' issues and that we received significant development funding in 2018. Our ambition is to ensure that the four strategic priorities of the national maternity strategy are delivered and that we continue to build trust and confidence in the general public for our maternity service. We know that this will take investment over a number of budgets, but our goal is to ensure that every normal risk woman can access the same range of services with the same level of quality, regardless of her location. This concludes my opening statement. I and my colleagues will endeavour to answer any questions.

Chairman: Thank you. I invite Dr. Peter Boylan to make his opening statement.

Dr. Peter Boylan: The Institute of Obstetricians and Gynaecologists welcomes the opportunity to engage with the committee in respect of the implementation plan for the national maternity strategy. The plan has 77 recommendations and 236 specific actions. While all of the recommendations are welcome, I will concentrate on those which the institute considers the most important.

Under the health and well-being strategic priority the commitment to prioritise the recruitment of consultant perinatal psychiatrists and multi-disciplinary team members is essential. There are currently only three perinatal psychiatrists in the country, only one of whom is full time, and all three are in the Dublin area. Women are badly served in this respect.

Under the safety and quality strategic priority, the continued development of national clinical guidelines and the emphasis on audit, using the Irish maternity indicator system, IMIS, data set, should improve the standard of care to women in pregnancy. There is a long tradition of audit in the Dublin maternity hospitals. A lot of work has been already done in the area of guideline development under the leadership of Professor Michael Turner, clinical lead in obstetrics and gynaecology. The involvement of the national women and infants health programme in this area is welcome.

There is a well-recognised deficiency at national level in access to ultrasound services. The institute regards correcting this as a high priority. Under the model of care strategic priority it is critical that the development of the three pathways concept and associated changes does not cause divisions between midwives and doctors. Midwives and doctors working in the Irish health service have a long tradition of working co-operatively together. Such is not always the case in other developed nations, sometimes with tragic results. Teamwork and mutual respect are in the best interests of women. Teamwork also refers to other health care professionals, such as pharmacists, etc.

Development of special services such as early pregnancy assessment units, neonatal screening programmes, perineal clinics and perinatal pathology services will require substantial increases in staff numbers. Under the governance and workforce strategic priority the institute welcomes the repeated emphasis on the importance of audit in maintaining patient safety and

quality. The institute strongly supports clinical leadership in governance of the developing maternity networks within each group. The maternity lead should be a senior clinician with both authority for implementation of the plan under discussion here today and accountability for the success, or otherwise, of implementation. Without authority, however, the lead should not be held accountable. The mastership model, as operated by the three Dublin hospitals, but with adaptation, could serve as a model for governance in this respect.

The deficiency in medical staff numbers is a cause of serious concern. It is well known that many consultant jobs are so unattractive that no applications are received. This is a major change from a decade ago and requires urgent and realistic action by the State.

Benign gynaecology gets no mention in the national maternity strategy and we regard this is a serious deficiency which needs to be addressed. I would add that having listened to Mr. McGrane's presentation that a lot of the issues are being addressed and what he said is welcomed by the institute.

Chairman: Thank you very much, Dr. Boylan. Will Ms Phil Ní Sheaghdha read the opening statement?

Ms Phil Ní Sheaghdha: Our first vice-president is going to read the opening statement.

Ms Mary Leahy: Thank you, Chairman, Deputies and Senators. I would like to introduce my colleagues. I am joined by Ms Phil Ní Sheaghdha, general secretary of the Irish Nurses and Midwives Association, INMO, who will give a detailed analysis, including figures, on recruitment and retention issues associated with midwifery, and Ms Mary Gorman who is a practising midwife and member of the executive council of the INMO. I am first vice-president and a public health nurse and midwife as well.

In January 2017 the Irish Nurses and Midwives Organisation appeared before this committee and welcomed the launch of the country's first National Maternity Strategy - Creating a Better Future Together 2016-2026. Our midwives section has particularly welcomed the recognition, within the strategy, of the need to give pregnant women appropriate and informed choices in respect of their care during pregnancy, supported by access to the correct level of care and support for their individual needs.

One year on, the progress in implementation is very slow. We have not developed any further midwifery-led units despite the positive feedback surrounding this model of care. Likewise, the development of community midwifery services remains at planning stage. Recommendation 41 of the strategy regarding hospital outreach community midwifery services was due to be fully implemented in the first quarter of 2018 but this has not occurred.

Arising from a recommendation of the report on maternity services in Portlaoise General Hospital, directors of midwifery have been appointed to all midwifery units, 19 in total. One important thing to note about these appointments is that the post of director of midwifery has a remit which spans both the maternity hospital and the adjoining community services in the context of implementing the maternity strategy. The INMO believes that the hospital group structure must provide for the same policy and governance at group level for midwifery services, as is the case for general services. Therefore, the appointment of group directors of midwifery is a necessary national driver for policy and governance changes. The implementation plan published in October 2017, which the INMO was briefed on, set out a plan for the establishment of a midwifery network within each group as a priority and stated specifically that by the second

quarter of 2018 a maternity network governance structure would be in place with a network manager, clinical lead, midwifery lead and quality and patient safety lead clearly identified.

Discussions have not taken place with the INMO yet in relation to the national governance model. The INMO believes that midwifery services would benefit from a national governance model like the way in which general hospital governance is enhanced by the national role of group directors of nursing. The INMO is becoming increasingly concerned at the slow pace of implementation of the strategy and with the low midwife to birth staffing ratios which continue to exist in this country. The accepted midwife to birth ratio, which arises from evidenced based practice, is one midwife to 29.5 births. The strategy committed to the introduction of this ratio over a number of years.

As part of the 2017 funded workforce plan the HSE committed to increasing the staff midwifery numbers from the December 2016 census figure by 96 whole-time equivalents, WTEs, at December 2017. The most recent figures presented to the INMO by the HSE in late January 2018 show that the overall number of staff midwives had actually fallen by 16 whole-time equivalents in December 2017. We have furnished these figures to the committee already. The reality is that our maternity services are severely understaffed and, from the experience of the INMO, there is a funding barrier to realistic workforce and manpower planning services at undergraduate level and continuing at post-graduate level in all aspects of planning. Midwifery is a profession which requires continuity of staffing levels and it is a concern that the highly pressurised environments in which midwives' work do not lend themselves to retention of staff. The pay for midwives is modestly low for the responsibilities held. The Public Service Pay Commission is currently looking at the barriers to recruitment and retention in nursing and midwifery in Ireland and we have made a detailed submission to this body, demonstrating the fact that Ireland is currently the lowest paying country for nurses and midwives of the five main international recruiter competitors. Ireland is currently unable to retain or recruit sufficient numbers of nurses and midwives to continue to provide safe levels of care in the current models of care delivery. A major improvement in relation to pay and recruitment and retention planning is required to improve midwifery staffing levels and provide sufficient numbers for the expansion and development of services such as those envisaged by this strategy.

I thank members for their time today. We will be happy to answer any questions.

Chairman: Thank you very much, Ms Leahy. We are now going to open the discussion to members and the first contributor is Deputy Billy Kelleher.

Deputy Billy Kelleher: I welcome the witnesses and thank them for their presentations. The national maternity strategy was launched some time ago and our role is to see how much has been implemented and whether resources have been made available to same to ensure we have safe and uniform maternity services across the country. In that context, one of the important issues that has been consistently raised is the lack of uniformity in terms of services available to women. One area would be the issue of scans. For example, in Dublin, most women would be able to receive a scan, but in other parts of the country it would only be if there was a high risk, or if they were identified as having potential problems. In that context, how much progress have we made in the area of making a scan available to every woman at 12 weeks and at around 20 weeks? Is that something that needs an awful lot more infrastructure or is it personnel? What are the delays in rolling out that uniform service across the country?

Another area highlighted in the report is that due to a variety of contributing factors, including demographic, lifestyle medical co-morbidities, maternity care in Ireland has become

more complex but despite this, perinatal and maternal mortality rates remain low. However, challenges remain and the proportion of complex pregnancies is increasing. Caesarian sections are increasing, the proportion of low birth weight babies and pre-term babies is increasing and breast feeding still remains very low. While we have, and it is acknowledged as such, a fairly safe system in terms of mortality rates, there are huge challenges in terms of outcomes. What are the main reasons behind these issues regarding the complexities, the co-morbidities and the low birth weights? Is there anything in the strategy to address that in terms of trying to identify early on and deal with the underlying demographics, the underlying societal problems and the underlying health problems in advance of even pregnancy - in other words, educating people well in advance of pregnancy?

There are 19 maternity centres. Can they all remain as is? Does there need to be realignment or reconfiguration or even amalgamations? A key component of the maternity strategy is to have birth centres alongside delivery wards. How far advanced are we in rolling out birth centres across the 19 maternity units?

In terms of personnel and recruitment of consultant obstetricians and midwives, the Public Service Pay Commission is looking at pay rates but are there more fundamental, underlying problems affecting recruitment such as the pressure the system is under and the potential problems for indivdiuals if things go wrong? I refer to law suits and culpability and other such issues.

Chairman: I thank Deputy Kelleher. We are going to bank some questions. I will bring in three members and then we will go to the witnesses for their comments. The next speaker is Deputy Alan Kelly.

Deputy Alan Kelly: The witnesses are very welcome. I will not go over some of Deputy Kelleher's questions as they overlap with some of mine. I am a big supporter of the strategy. I have publicly stated that on numerous occasions and we have discussed it at length in the committee.

An organisational chart of the strategy showed the various directorships and positions where there was a delay in filling initially. Have all the roles been filled and down to what level? We need an update on that. I understand that at the highest levels, the programme director, clinical director and director of midwifery have all been appointed but have all appointments been made?

There are big concerns about perinatal services. I keep raising the issue. Have there been any improvements since the witnesses were last with us? In relation to the services provided it is estimated that at least 10% of pregnant women have some form of mental health issues. There is a lack of psychiatric services. Are we going in the wrong direction? Is the system stalled or are we making progress?

I would like to hear the views of witnesses on staffing numbers across the various disciplines. I have taken on board what has been said about the mastership model. I think that is the right model. I would like to hear how it will be implemented across the board.

In terms of the announcement last week of the national development plan and the capital plan, we know that within the ten-year maternity strategy certain milestones have to be met. Will we make up the time we have lost given that a couple of years have been lost? I know the maternity facility in Limerick quite well. I came through it myself and I have experienced the

fantastic service there but the physical infrastructure is not adequate. The sum of €3 million was required in order to even carry out the assessment and planning but that was not found so we have lost a couple of years. What are the views of witnesses in relation to that?

I am very much taken with community midwifery services. The midwife-to-birth ratio is deeply concerning. That is something we need to air here so that we can leverage the committee to address it.

The strategy envisages the doubling of consultant obstetricians over ten years. We are not achieving anywhere near that so how are we going to address the issue? Those numbers are required by the strategy.

An issue I raised previously with the witnesses is training in ultrasound. Have we made progress in that regard? It was outlined to us previously that the lack of progress in this area would hold up the services we need to provide to women and children.

Deputy Louise O'Reilly: I apologise for missing the first few minutes of the meeting but I did get a chance to read the submissions. Recruitment and retention are mentioned by both groups. There is a deficiency in medical staff numbers. Dr. Boylan referred to consultant jobs being so unattractive that no applications are received. Ms Leahy referred to the recruitment and retention crisis. Before we move on to start talking about anything else it might be possible for us to do we need to generally accept that none of that will be done unless we have the men and women who are capable, trained and willing to work in our services to deliver it. I am interested to hear the views of witnesses on what can actually be done. We know that pay is a major issue. I do not think that is lost on anyone here but we also know that there are other elements and it might be possible to expand on that in terms of professional development and making the health service a more attractive place to work.

I direct my question about the 20-week anomaly scan to Mr. McGrane. I am genuinely sick of the sound of my own voice talking about the issue at this stage as I have raised it so many times. Whatever way one wants to dress it up, there is a postcode lottery in place at the moment. If one happens to be pregnant in certain parts of the country one gets a hugely different service. That is not about the quality of care, because the people who deliver the service are working extremely hard, but the system is working against those people and it is working against pregnant women. I have asked the Taoiseach about it and the Minister for Health and, with respect, they occasionally defer to Mr. McGrane although he is not there when they do it and I have an opportunity now to ask him. Could he give us an idea when pregnant women in this State can expect as a matter of course – in the way they do in other countries – to have access to a 20-week scan?

Could Dr. Boylan and perhaps Ms Leahy explain something to us? It has been said to me a number of times when I have asked the question that the scans are provided where they are clinically indicated but the professionals tell me that it is a screening scan so therefore it cannot be clinically indicated without a scan. To me, that seems like a bit of a merry-go-round.

Dr. Boylan referred to benign gynaecology not being mentioned in the maternity strategy. Could he elaborate on that for us because we have heard evidence about the waiting lists for gynaecological procedures and how they operate and the pain and distress women are in while they are waiting? Could he elaborate on why he thinks it is not there and perhaps Mr. McGrane could advise us why it is not in the strategy?

I echo the point previously made that the strategy is now two years old. I know that some of the implementation plan was not launched at the same time as the strategy. We have lost time on it and, again, it is not about having a wonderful document because clearly we have a wonderful document but it is about knowing when we are going to hit those milestones and if we can, if possible, make up the time lost.

Ms Phil Ní Sheaghdha: I will concentrate on the issues generally that have been asked about staffing. It is very important to give some raw data in respect of the numbers. For example, there were 1,445 staff midwives employed in the public health service in Ireland at the end of December 2017. That was a reduction of 16 on the number employed in December 2016. That tells us two things. First, it tells us we are not training enough midwives and, second, we have an inability to retain them.

We train midwives in this country in two different ways. We have a direct entry midwifery programme and we have a postgraduate higher diploma in midwifery for general nurses who want to change career and become midwives. That programme has not met the target numbers for the past two years. In other words, the applications are down. It is a very good programme and it allows nurses who wish to train and work as midwives while training to qualify and thereafter register as midwives. Deputy O'Reilly asked what we can do in the short term. We know the problem is that the pay rates are too low for nurses in general and for midwives particularly. Deputy Kelleher asked if it was the litigious nature of the job. There is no doubt that the pressure on midwives and the public appetite to get somebody to blame have most certainly not helped retention.

Dr Boylan made a very important comment. Nurses and midwives work very well with their colleagues, obstetricians, gynaecologists, etc. There is a lot of co-operation in the area of midwifery particularly. As a profession, it is very independent in its practice. That is why we welcomed the strategy so much, particularly in respect of developing services in the community. In many jurisdictions, these services are delivered by midwives. Our disappointment centres around the midwifery-led units. We still have two: one in Our Lady of Lourdes Hospital and one in Cavan. The feedback from the women who attend is very positive yet the development has not progressed beyond what was there when we last met the committee.

As to where we get midwives from when we cannot recruit and retain our own, the most recent figures from the nursing and midwifery board, An Bord Altranais, show us that the general service relies on recruitment from non-EU countries, particularly India and the Philippines, to make up its numbers. That is not the case for midwifery as the qualifications do not transfer. We have to concentrate on what we are doing at home to a greater extent, as we cannot rely on non-EU recruitment. We have some EU recruitment, particularly from Portugal and Italy. We recruited and registered 19 in 2015, according to the last statistics. That has gone up slightly but, of course, there is an issue with language. That has to be taken into account.

We have two possible remedies. If, for example, I want to do the postgraduate diploma in midwifery in Limerick but there is not a place there, I will go to the Coombe or the Rotunda. However, I will not then be offered employment in Limerick. It is bureaucracy. There is a very simple remedy. The circular needs to be amended to ensure that whoever sponsors me employs me once I qualify as a midwife. That requires me to relocate. The good thing about the postgraduate programme is that the students are usually more mature people. They have done their initial qualification as a registered general nurse and are therefore more likely to stay. They are obviously very interested in changing career and becoming midwives. We have to work harder at making it attractive, to ensure that people do train as midwives after qualifying as general

nurses and that it is not an expense on them. They should not have to maintain two locations from a living perspective and should not have to do their second qualification away from their base. Many of the postgraduates are currently dropping out and the numbers are not being met this year. Very disappointingly, we have not even filled half the places that are available. The remedies are there; we just need to focus on them. The strategy will not be implemented unless we get enough of our own training as midwives.

Likewise, on the undergraduate programme for direct entry midwives not all the places are being filled. Again, we have to ask why and we have to make sure that students are supported in clinical practice. It is very intimidating, particularly in hospitals that are not maternity only, for student midwives who are training and are being rotated into a general site. They need clinical facilitators and clinical practice co-ordinators to make sure they are confident while learning. Unfortunately, the numbers are very low. The general population of midwives is very low.

Midwives also avail of maternity leave themselves and we know replacement posts for maternity leave are just not happening across the service. There is a deficit of about 3% in the workforce as a result. Those on maternity leave are counted as part of the numbers as if they were at work even though they are not. Those are some of the issues that were raised.

Deputy Louise O'Reilly: I feel strange calling Phil Ms Ní Sheaghdha. With regard to recruiting nurses from overseas, at what stage are they counted as part of the whole-time equivalent, WTE, figures? Ms Ní Sheaghdha mentioned the language barrier. Nobody is suggesting for a moment that these men and women are not very welcome and very necessary. We know that. From my own experience and from talking to nurses and midwives, however, I know people are sometimes counted who are still in a period of training or adaptation. At what stage are they considered part of the WTE complement? Are the figures a wee bit skewed by the inclusion of people who are on maternity leave and people who may not be fully up to speed?

Ms Phil Ní Sheaghdha: The HSE tells us that once a person is placed on the payroll, he or she is counted, regardless of the orientation or adaptation that is required. There is a deficit. For those from non-EU communities, there is a period of adaptation that is required by An Bord Altranais. For those from EU member states, it is not the same; it is more about preceptorship and orientation to a different workplace.

Chairman: I will bring in Ms Angela Dunne.

Ms Angela Dunne: In respect of the competency of a particular midwife, some would take longer to adapt and others a shorter period. With regard to the recruitment of midwives, the committee members will be very aware that public confidence in the maternity services is poor. That is something we have to work on. If we do not start regaining that confidence, we are not going to retain our midwives. It is a huge part of our role.

We have had our midwives leaving the country because they want to practise normal midwifery. They want to get experience in supportive pathways of care. We need to start implementing our supportive pathways of care. One of our actions for 2018 is that 20% of women in all maternity units will be offered a supportive care pathway. That is the first step.

We also need to look at the career pathways of our midwives. We have in place a number of clinical midwifery specialist posts in bereavement, sonography and perinatal mental health. We are also putting in place the advanced midwifery practitioner posts, which will be another career pathway for our midwives. There are also the managerial roles such as shift leaders and

clinical nurse manager 3, CNM 3, posts.

The directors of midwifery have really made a huge change on the ground in the 19 maternity units. The tertiary hospitals did have directors of midwifery. I have seen a huge change in the last year in this regard. They are the catalysts for change on the ground. They are addressing the issues. They are the advocates for resources, staff and the implementation of the maternity strategy. There is a hunger for this model of care. I am not just referring to the supportive model. As Dr Boylan said, we work very well as teams on the ground and do not want to break that. The strategy is about the three models of care. It is about continuity of midwifery care through the three pathways.

Chairman: Other members referred to the availability of anomaly scanning. Perhaps Dr. Boylan might like to address that issue.

Dr. Peter Boylan: It might be better for Mr. McGrane to answer that as it is more his area.

Mr. Kilian McGrane: Deputy Kelleher raised the scans at 12 and 22 weeks. It is a matter of both personnel and infrastructure but is predominantly a personnel issue. Through the maternity networks, we have identified that an additional 28 ultrasonographers are required to deliver anomaly scanning to 100% of women. More sonographers are required to ensure that dating and anomaly scans are provided for all women. We have put the investment in this year. There was ring-fenced money for anomaly scanning in the budget and that investment is going out this week into the system. We know there will be a challenge in getting the number of people needed. Over the course of the last year, in a number of locations, they have already started to upskill midwives if there is a difficulty recruiting sonographers. That is specialised training. The issue is almost exclusively personnel and it is twofold. The stenographer carries out the ultrasound and does the counselling with the woman in the clinic, while foetal medicine expertise is required if an anomaly is identified.

My colleagues will comment on safe systems. I was asked about the 19 units. To date we have had no safety concerns with any of the 19 units but my colleagues will talk about them from a clinical perspective. Deputy Kelly asked about populating the women and infants team. It is a seven-person team, made up of the three of us sitting here and another four sitting in the Gallery. We have a person to deal with quality and safety, another who has a business intelligence background and two who do general project management support. We will hopefully have two or three more and a recruitment process is under way, although this is not slowing us down.

I was asked for an update on perinatal mental health. A programme was launched in November last year by the HSE mental health directorate under Dr. Margot Wrigley, which is a specialised programme for perinatal mental health. It had €1 million in funding in 2017 to address issues such as psychiatry, and it has €2 million for 2018. The team will put in the specialist posts in perinatal psychiatry, psychology, specialist nurses and social work, and the programme will then move onto clinical midwife specialists in mental health, who will support midwives on the ground to ensure the care pathways are in place. The launch and the ring-fenced funding announcement were very welcome.

Two former masters are sitting here so I will be careful about what I have to say about the mastership. The mastership model works very well in the Dublin voluntaries and they have boards. There will be challenges for us in moving the model into a HSE-run environment. The best example is in the south-south west group, where Professor John Higgins has been appoint-

ed as the executive clinical director for the maternity network. It is a work in progress and we can learn a lot from the Dublin maternity hospitals but we need that level of clinical leadership. The model in the Dublin maternities is unique to Ireland, has worked very well and has served the system extremely well so we need to find out how to adapt it to other areas.

I was also asked about capital and making up for lost time. The national maternity hospital is moving ahead as planned. We identified Limerick as the next highest priority behind the national maternity hospital, because of risk factors with the blood bank. The other two Dublin maternities are also on the list and we hope the announcement will mean an acceleration in the ability to draw down funding. Ms Dunne will talk about community midwifery. The Birthrate Plus report was launched in 2016, which was an analysis of what the appropriate midwife to births staffing ratio was at the time, based on a 2014 audit. It recommended a 35:1 ratio but said we need to get to 29:1 when we implement the model of care. We agree fully with the INMO in this respect so there is a significant journey to travel. We will support 75 additional midwives with investment this year, which is a positive first step though there is a considerable distance to travel beyond that.

Deputy Kelly also asked about the doubling of consultants. The nine we will get this year is a good start though we would have liked more. I am not sure if Dr. Boylan thinks we could have got more. We hope that the 100 that were identified will be recruited over the course of the next ten years. Deputy O'Reilly asked about recruitment and retention and my colleagues will respond to that. We have the same challenges as Deputy O'Reilly in that the issue of anomalies in scanning comes up repeatedly. There are seven units which provide 100% access, seven units which provide partial access, usually where clinically indicated, and five where there is no access. The clinical indication does not always come from a scan and it could, for example, be age-related because in some locations this will apply to women who are older than 36 or 38. We have worked with all of these and some have made progress already, to move beyond where they were this time last year. The south-south west area has a very good plan which it hopes to implement whereby all its sites would be able to provide 100% access this year. I will not commit the area to a timeframe because recruitment will be a rate-limiting factor.

Deputy Louise O'Reilly: Is it not part of the problem that you are not committing to a timeframe? I keep asking at what stage in the future we will be able to say to a pregnant woman that she will definitely have access to this. The answer is always "perhaps in a while" or "maybe in a bit" and "we are definitely committed to possibly doing something". I appreciate that Mr. McGrane has a tough job but if he does not set targets there will be a problem. If I was a trainee midwife, why would I want to come and work in an area where no targets were being set and I could not see any improvement coming down the line?

Mr. Kilian McGrane: The difficulty for us is recruitment. There is not a bank of trained stenographers available. In radiography there is specialised training in ultrastenography as one pathway, while there is another for midwives to train and do the masters programme. We met with the provider of the masters programme recently and we will continue to collaborate. I would love to be able to say definitively but, as our opening statement said, we do expect most of this to be addressed in the next 18 months. We will keep a very close eye on it and try to ensure the pathway for women improves even where we have not got 100% access in place.

Deputy O'Reilly also raised the topic of benign gynaecology, which Deputy Kelly asked about last year and which Dr. McKenna will address shortly. It was never envisaged that benign gynaecology would form part of the maternity strategy. It was acknowledged that it needed to be managed within the women and infants programme and my colleague has started a process

to develop a strategic plan for it. The only way we can approach it is to adopt a similar methodology to the national cancer control programme, where there are specific timeframes whether a case is urgent or less urgent and we are resourced to meet those timeframes. It is very damaging to women who have a condition with which they have to live for prolonged periods.

Dr. Peter McKenna: Benign gynaecology is not prioritised in many hospitals and if there are pressures on beds it will be cancelled. There are no dedicated day theatres or day beds in many hospitals. It is one of the specialties with the largest waiting lists and unless it is resourced properly colleagues will not have access either to outpatient or theatre facilities. There are imaginative ways in which it can be addressed but it has not had the priority within hospitals which it has needed.

The 19 centres deliver more than 1,000 babies and that is a lot by international standards. The four big hospitals deliver between 8,000 and 9,000 and that is massive by European standards. One cannot say any of the units is too small by international standards. Our remit is not to close units but to comment on their safety and we have no concerns as regards the smaller units. It may become more difficult to staff them and the posts may become less attractive but that is a separate issue from the question of closing one over safety issues.

Another issue is patient complexity. Patients are getting older, which is happening through demographics and postponing families. Patients are getting larger, which is happening at an alarming rate and which causes increased morbidity. More patients benefit from assisted reproduction and an increasing proportion of women are having their first baby as families get smaller. These factors all feed into increased complexity. The population is becoming more complex from the point of view of maternity and Dr. Boylan will comment on this.

Money is an issue in consultant recruitment but so is workload and quite a lot of work in maternity services could be on an on-call basis. If someone works in a smaller unit, they may be on a four-person team. That is committing that person to a lifetime of on-call after holidays of one in three. The question of compensation or inducement is very clear but, similarly, there is also the issue that should anything go wrong, the individual has the regulatory authorities and the press to answer to. It is not very attractive, as the committee can well imagine, for somebody who has set out on a professional pathway to find themselves the object of adverse attention in the press. It is measure of incentive and the fact that elements of the job may not be very attractive but I am sure Dr. Boylan will have a similar viewpoint.

Chairman: Dr. Boylan will address some of the issues.

Dr. Peter Boylan: Several points have been raised, some of which are overlapping. With regard to the complexity of pregnancies, Dr. McKenna is absolutely correct. Women are getting older when they are having their children, particularly their first baby. Many of the complex problems associated with assisted reproduction are the result of donor egg pregnancies. One finds women in their late 40s and perhaps into their 50s presenting with pregnancies, sometimes with twins. They also have hypertension or diabetes so their pregnancies are far more complex than would have been the case a decade ago. This presents particular challenges for management. It places extra demands on those consultants working in the system.

Women are also coming through who have survived as a consequence of excellent neonatal care. For example, women who had surgery as newborn children for complex cardiac conditions are now coming through and reaching the time when they are having children. This is obviously another area, so there are a lot of complex medical problems among women at the

moment and things are becoming more complex. Of course, obesity is a major issue in Irish society.

Regarding the litigious nature of the job, pregnancy is generally expected to be a happy event where everything goes very well normally and one gets a healthy baby at the end of it. Consequently, when things do not work out, the consequences - the disappointment, anxiety and grief - are much more accentuated than if somebody goes into hospital with a long-term illness and maybe dies after surgery or after being in hospital for a prolonged period. The expectations are different from the rest of medical practice. When things do not work out as expected, the natural inclination of people is to wonder what went wrong, why it went wrong, whether anyone is to blame for this or whether it was a mistake or a negligent mistake where people did not take due care. That places an extra strain on people working in the system. When something goes wrong, such as when a baby dies or is damaged as a consequence of a human error, the people working on the ground need to be regarded as the second victims in this scenario. They feel it deeply, particularly the midwives, because in crises they are of tremendous assistance but they are not the ones making the decisions. They may sometimes see things happening with which they disagree and they are right, so for them to see something go wrong and to know that the doctor has done something wrong but has ignored their advice is particularly hard on them. Young trainee midwives go into it and see many happy births - it is a tremendously rewarding profession - then something goes wrong and they are in the midst of this maelstrom of grief, anger and blame.

One of the problems we have, which relates to the retention of staff, is the fact, as mentioned by Dr. McKenna, that sometimes there may be three or four consultants staffing a smaller unit. With holidays, study leave and so on, that works out at each consultant being on-call every third 24-hour period and every third weekend from Friday morning until Monday morning when they carry the entire responsibility for what is going on. What frequently happens is that a locum or an agency doctor consultant will be brought into a smaller unit over the weekend. In a bank holiday scenario, the agency consultant will have come on duty on the Friday. In the event of a catastrophe at 9 p.m on that Friday, the consultant who had been attending to the patient will have been away and will come back on the Tuesday morning after the bank holiday. There may well have been agency midwives as well. The woman will have gone home but nobody will have informed the consultant or the midwives working on the ward and they are all very busy running around. The woman will go home and effectively is almost abandoned. When the consultant meets her - possibly because the general practitioner will have contacted the consultant - he or she does not really know an awful lot about the case and is taken unawares. That is one area where the network development is very important. It is in its infancy and it will take time. If one has a network, one will have audit of all of the outcomes - all of the births, caesarean sections, adverse outcomes and so on - as is the model in the larger units, particularly in the Dublin hospitals on a weekly, monthly and annual basis. It is like running any good business. People running a hotel need to know how many guests they have, how many were happy, how many were disappointed, bed occupancy and revenue per room etc. In the same way, from a clinical perspective one needs to know what is happening to the women coming through the door with regard to their outcomes, how many of them got infected, how many had blood transfusions, how many had caesarean sections, how many babies went to the neonatal unit etc. All of that needs to be done continuously. This is where the network audit system that is being instituted by the office is extremely valuable and will make a huge contribution to improving safety and quality in the future.

The other thing about working in a smaller unit is that by virtue of the on-call commitment

these consultants have, they will run out of their pay for being on-call to such an extent about half way through the year or maybe earlier. After that, they are working for the State on-call for free. That is a problem. I do not think any other person working in the health service would work for free. We would not find the porters, laboratory people or anybody else saying it was fine and that they had earned their cache of overtime for this year and would work overtime for free for the rest of the year. I do not think that would happen but consultants have been doing that for years. That is a problem that needs to be addressed.

I have spoken about the recruitment and retention of consultants. It may well be that if a new contract is negotiated with the Irish Hospital Consultants Association and all the consultant groups, it may evolve into something along the lines of the Australian model where doctors get paid for their public commitment and have a choice as to how much public commitment they give. They have a choice as to how much public commitment they give but they must give a minimum. So one may find a doctor who says they want to give four sessions a week to the public service and spend the rest of their time in the private sector. They only get paid for their four sessions in the public service with a relevant contribution to a pension fund which they can manage themselves. That is a huge advantage to the State. It works for the doctors because they can do what they want in terms of commitment to public or private practice and it works for the hospital because it knows exactly what the doctor is due to be doing. It is a system that works very well in Australia so it is something that might be worth looking at.

Deputy Billy Kelleher: Is there as much continuity in that type of casualised-----

Dr. Peter Boylan: One does get continuity because a lot of doctors just want to stay in the public system because it is more comfortable and less challenging in terms of generating one's own income and so on. All of the midwives are also providing continuity of care and that team work is really important in that there is continuity of care that way. It is a concern. One would not allow a consultant to have one session a week in the public service. One would have to have a minimum amount to make it realistic.

Linked in with that, reference was made to the master shift system, which works extremely well in the single stand-alone maternity hospitals. The model of the south-south-west system that was mentioned, of which Professor John Higgins is the executive clinical director, is one that needs to be developed for all the networks, but it is really important that maternity services, including gynaecology, have separate governance and separate budgets, just like the cancer strategy. A separate budget is critical. What happened in Cork is a classic example of where that can go wrong; the budget for maternity services was eaten into by the general hospital. As Dr. McKenna said, the first thing to get sacrificed is gynaecology; women's health care gets sacrificed first when there is a push. A separate budget and co-location of the maternity hospitals with the general hospitals are critical, as opposed to integration because then they get sucked into all of the problems one gets in the general hospitals. When a crisis arises in the emergency department and patients are on trolleys, where do they go? They go to a gynaecology ward. What gets cancelled? Gynaecology. Obviously, one cannot cancel obstetrics.

Benign gynaecology has been dealt with. Regarding perinatal mental health services, we have heard that those are being improved and that is critical. With respect to the capital plan, the development of the new hospitals is welcomed but co-location rather than integration is a critical factor as well as having separate governance and separate budgets.

I mentioned in my opening statement the importance of midwives and doctors working together as teams. It is critical we do not lose the tremendous co-operation and teamwork we

have had between midwives and doctors in the Irish health service down the years. There is a terrible tendency to look to the UK and say what they are doing is good and, therefore, we will do it. It is not always good. It has had very serious problems in its maternity services. We do not want to repeat the mistakes of separating out midwifery and obstetric care. There are both the same. All obstetricians are midwives and are proud to be midwives but they are also looking after more complicated cases. It is essential they work together and that we do not lose sight of that.

Chairman: Thank you, Dr. Boylan. I will bring in other members and we can then come back to some points that might not have been covered. I will bring in Deputy Murphy O'Mahony, Senator Burke, Deputy Durkan and Deputy O'Connell and in that way I have included all the members. I call Deputy Murphy O'Mahony.

Deputy Margaret Murphy O'Mahony: I welcome all the witnesses. Nearly every question I intended to ask has been asked by my colleagues and fair play to the witnesses for having answered them more or less adequately. Recruitment and retention of staff will be a major problem. The witnesses might elaborate on how that issue can be resolved. Obviously, if we do not have the staff, there will not be a strategy. Staff are an essential requirement. More emphasis needs to be put on that issue. I would like to hear the witnesses' comments on that.

The issue of fertility is part of the maternity strategy. Not every women is lucky enough to get as far as being in a maternity hospital to give birth. The witnesses might indicate their thoughts on that issue.

Senator Colm Burke: I thank the witnesses for their comprehensive presentations. Gynaecological services in Cork were touched on. Is there any update on that waiting list, as 40% of all the people waiting for those services are on the Cork waiting list? Is there any update on the current status of the waiting times for those services in Cork and the numbers on the waiting list? The witnesses might provide some clarification on that.

On adverse events and support for staff, I come from a legal background and I have found on a number of occasions that there has been a lack of support for staff when an adverse event occurred. Some units are very good in providing that support to staff, but I am not sure if such support is given in every unit. I have even come across cases where an adverse event occurred which subsequently involved an inquest and the staff prepared statements without being given any support in their preparation and were facing into an inquest without having been given any support prior to it. Is there a procedure in place to ensure that staff are getting support not only initially after the adverse event occurred but following on from it and checking back with them to make sure they are able to deal with the issues that arose? The witnesses might comment on that issue.

On the issue of staff leaving the services, and there are 19 units around the country, is there any evidence that a higher number of staff are leaving a particular unit or is the number leaving the units similar across the board? Has any analysis been done on that? Is there an interview process in place prior to staff leaving the services to establish the issues they have had to deal with, the reasons they are leaving and whether it is due to a family commitment, because they are leaving the country, the salaries or the stress levels? This also applies to trainee doctors. I recently came across two trainee doctors who had been in the obstetrics and gynaecological area for six years who decided they could not deal with the stress levels and have now decided to go into GP training. Has that issue been examined?

We talked about the 2003 report that was published that dealt with the need for consultants. It identified that there should be 180 consultants by 2012. The number we currently have is 130 to 135. People will be retiring. Have we forecast the number who will be retiring? If we are talking about replacing nine additional posts this year, what number will be retiring? That issue must also be dealt with. That ties in with the number of people training in obstetrics and gynaecology who are on the specialist register or who want to get on to it. Are sufficient numbers coming through the system or will we be seeking to recruit from outside the State to fill any targets we set? Have figures being prepared on the number who are retiring, the number of new jobs we need to create, and the number who are in training?

On the issue of nursing staff, figures were given for the number of staff nurses and we heard that the number had decreased compared to 2016. Are there actual figures for the number of people who are in training and do we know what their intentions are once they complete their training? Has a survey been carried out on that? Is it the case that they intend to leave the country? Do we have any idea what their intentions are, especially the people who will complete their training over the course of the next 12 months? That would give us an idea of nursing staff numbers. I thank the witnesses for dealing with the issues they covered.

Chairman: I remind the witnesses to ensure their mobile phones are switched off, as a phone rang there. They interfere with the recording system. I ask the witnesses to ensure their phones are turned them off completely or to switch them to airplane mode. I am sure it was not the phone of any of the members.

Deputy Bernard J. Durkan: Never. Like others, I welcome the witnesses and I thank them for their interesting address. Regarding the deficiencies in the postgraduate and undergraduate courses and the location of adequate encouragements, for want of a better description, to ensure the people who embark on those courses have a place to go and are sure of where they want to go at the end of them, to what extent do the witnesses bring that to the attention of the authorities? I am a great believer in the chain of command, and I am sorry about the director who, unfortunately, must take responsibility for all of these things as it is a difficult position, presuming the director has a full and total free hand in delivering the services we are speaking about. It is a two-way process. How does it work? What happens when the director responds to the queries coming from the ground? Does anything happen? Is it slow? Is there a possible resolution? If not, why not?

With regard to the risk factors, and looking at a number of cases that have come up in recent times, I feel very sorry for the professional people involved. I have to say I am equally sorry for the unfortunate victims in those circumstances. No matter how sorry one is for the victims, it does not replace the person who has gone, whether it is the mother or the child. Something has to be done about bank holiday weekend cover. We need to do something about it as a matter of some urgency. There are no circumstances in my opinion where a woman going in for a crisis pregnancy or a normal pregnancy should be in a situation where her consultant is missing and cannot be there. In the event of an emergency arising it is a very daunting and lonely place for her to be. I note what Dr. Boylan said on overtime and the on-call system, but some means has to be found to protect the lives of those who may be at risk in those circumstances. Quite frankly I do not care what has to be done but it is time to do it. There is no time for discussion afterwards. There is no sense going into court afterwards and stating something went wrong and people are sorry it happened. Of course we are all sorry it happened, but it is a sad thing that it goes to court.

I am only a simple member of the male population but problems with the provision of oxy-

gen during birth seem to occur more than occasionally. I do not know why this is. There must be somebody who knows and who is familiar with the procedures who should be asking questions as to why it happens. We are told all of the time that we have one of the safest systems in the world. If that is so, why should this occur? Should a different procedure be followed at an earlier stage to prevent it happening? Who is the decision maker? Is advice available to the person on the ground on his or her own who may be making a very serious decision in a very short space of time? Can that person refer to anybody further up the line? With modern technology, or whatever the case may be, is it possible to do so? If not, why not? It is totally unfair to have a situation whereby the person in the ward at the time of the emerging crisis is left alone to make a decision or has insufficient authority to make a decision. I know about the clash between doctors and midwives and I am not referring to this. There needs to be more than one person involved in making that crucial decision. It is crucial from the point of view of the professionals and, more especially, crucial for the woman and the baby.

Does the director have adequate resources in respect of maternity services? I know what the answer to that is. Does the director have adequate authority to make the decisions that are required to be made in a short space of time to ensure the best possible quality and standard of service is made available to those directly involved, by which I mean the mother, the baby and the staff on the spot in the maternity hospital? They are the people in the eye of the storm. They are the people who will be in the eye of the storm afterwards in the event of litigation.

It is much better to put in place corrective measures than to spend time defending in court what appears to be the indefensible. It may not be the indefensible, and there will always be accidents and we accept this. We cannot prevent accidents happening. However, a certain amount of accidents can be prevented and it is these we need to zoom in on and try to come to a decision on them and provide knowledge and back up.

The retention of staff at all levels comes up again and again. It will become more difficult. Way back some years ago benchmarking was introduced. Nobody ever admitted this, but while the cost of living was given as the reason this was not the case. It was the cost of housing that drove it mad. The cost of renting a house and the cost of taking out a mortgage have nearly doubled. Rent has definitely doubled and more than doubled over the past five or six years. This obviously will be a disincentive for anybody, particularly a young person going to work in the health services, or in any service for that matter. I make this as a passing point because we may have to find a way or means to do something about it. I am not saying we should go back to benchmarking, because we paid the price for that previously. It was the identification of the problem that was wrong and not the benchmarking. It was identification of the underlying problem, which was the inability of professionals to take out a mortgage or rent a house at any particular time.

Deputy Kate O'Connell: I thank the witnesses for all they do every day and I thank them for coming before the committee this morning. How we read this document depends on through what lens we look at it. Through the lens I am looking at it now I see the use of the word "women" and "mother" throughout the strategy. In acknowledgement of equality in Ireland, and out of respect, perhaps we could change that to "person" or "pregnant person", in light of members of the transgender community feeling the strategy does not refer to them in any sense. I take slight issue with the term "mother" being used because sometimes one does not ever get to become a mother. One may get half-way there or three quarters way there. I would like the language to be tidied up a bit, in light of all I have learned in recent years.

I had a quick search of the document for the words "termination", "abortion", "crisis preg-

nancy" and "the eighth amendment" and I can only find one reference at the bottom of page 36. Whatever one's views are, it seems very unusual or strange that the document could be written without any nod to the impact of Article 40.3.3° on maternity services in Ireland and the impact it has had on professionals working in the area. There is also the fact the HSE provides HSE-branded information for women seeking terminations in the UK, so it is not like taxpayers' money is not being spent. I find it very strange this is not even referred to in the strategy. Post repeal of the eighth amendment, I hope, at the end of May, are the witnesses ready to edit the document in light of the potential change that will happen?

Feedback from the midwife-led services in Cavan and Our Lady of Lourdes Hospital is good. Do we have any data on actual outcomes? What is meant by feedback? Is it just a chat or is it women reporting it was better than the last time? What is that tangible data? The Domino scheme is very successful in Holles Street hospital and I hear very good reports on it. There are geographical issues with rolling out a similar programme outside Dublin. Do we have any plans for rolling it out?

I understand that public health nurses do not require a midwifery qualification. Has an audit or assessment been done on that change in qualification, with regard to the outcomes for mothers, newborn babies and any children already at home?

With regard to folic acid and our alarming rate of neural tube defects in this country, how are we on this now? I know that the Food Safety Authority of Ireland has conducted a study of the safe upper limit for water soluble folic acid. Will we bite the bullet and start to fortify something that people could eat or drink to address the high incidence of neural tube defects? There is no need for me to explain the defects to the medical personnel present, but for the information of anyone listening to this broadcast, it means spina bifida and other health issues. Fortifying products would prevent some of the serious and challenging outcomes from occurring for parents and children as a result of poor pre-natal nutrition.

When he was here last year did Mr. McGrane say the health service was down 100 consultants? If so, we needed to recruit those consultants. Nine have been appointed. Did we lose any? What has been the net gain? What is the current position? Mr. McGrane said we would address the recruitment problem in the next ten years. The problem is that the health service is short 100 consultants. Also, it was projected last week that the population would grow by 1 million. I am sure some of them will be women who will look to have children. Obviously, demands are placed on health services owing to multiple births, the incidence of obesity, age, IVF treatment and other factors. To my mind, it is not good enough that in the health service there is a deficit in the number of consultants, unless Mr. McGrane spoke in error. If not, it is wrong for him to think it acceptable for women and their families - men, husbands and fathers - that it will take ten years to address a deficiency that was identified a couple of years ago. As my colleague said, women's health has been neglected for many decades and, possibly, a century. It is just not good enough to have corrective measures spanning ten years. Women are suffering and it is imperative that we deal with the deficiencies in the service as a matter of urgency.

The on-call issue must be addressed. I am fully aware that many doctors are not paid for being on-call and there is only so much time that their goodwill will last. Such work is unattractive. Someone would not be a consultant at 26 years of age but in his or her early 30s. It is grand being on-call and working every third night. However, we all know that as one gets on in age such work gets harder. It is no way to have a career, a family life or a personal life. It is just not an attractive career and we are shedding personnel. I refer to what Dr. Boylan said about the Australian model. We must do something about how we attract people into the system

and keep them.

Ms Dunne said the level of public confidence in maternity care was poor. I disagree with her. I am not sure if her statement is based on research or what she is feeling, but I would say the level of public confidence in maternity care is quite high. I do not think anybody is terrified when a woman enters a maternity unit to have a baby delivered, but perhaps I am wrong. I had very good experiences when I used the public system and think the outcomes are very good, despite the deficits.

We have spoken at length about Sláintecare and anomaly scans. I am not sure whether it was here or elsewhere, but that does not matter. It is welcome that money has been released this week. We have also heard about the upskilling of personnel to perform anomaly scans. We have also heard about the difficulties owing to the job being repetitive and quite difficult and that if one has a bad day when there are a lot of anomalies, it generates stress. A year and a half has elapsed. Where are we now in dealing with the issue? It seems that there have been no tangible results. I fully acknowledge that it could not be an infrastructural or machine issue where one just buys the machines, that rather it is a people issue.

On the omission of gynaecology from the strategy, I do not want to criticise my own but the Taoiseach who is a doctor has signed off on the first page. It seems unusual that two aspects have been decoupled. I do not know how one can separate obstetrics from benign gynaecology when the same people do the same job and the two aspects are interconnected. Perhaps someone might make a suggestion in that regard. Do we slot an additional segment into the strategy?

On the mastership model, I fail to see how there is an issue with implementing it outside Dublin and ask the delegates to elaborate on the matter. I have heard that the model has worked quite well.

On triage policy and the prioritisation of scans for women based on data, a mother's age and the number of babies a woman is carrying, Professor Louise Kenny appeared before the committee some time ago. On that occasion we drilled down into the numbers and I extrapolated from what she had said that there was one case a week. That means that each week there is one child born somewhere in Ireland, perhaps in a regional hospital, with a condition that was not diagnosed prenatally. Whether it is 52 or 2 babies who are affected, that is just not good enough. In other countries it is standard procedure to scan. A scan brings peace of mind, but it also allows for preventative actions to be taken and measures to be put in place to be followed at the time of birth. The current measure addresses as a priority something that has been deficient for years; it is not a ten-year plan. From a director's point of view - I do not mean to be critical - I do not see this as being good enough.

Dr. Peter McKenna said there were imaginative ways by which the benign gynaecology issue could be addressed. I ask him to elaborate on the matter.

I am very supportive of having separate governance arrangements and budgets where there is co-location. It is co-location, not integration. There are historical reasons for the abandoning of women with gynaecological problems. Women seem to have accepted the fact that incontinence or having a prolapsed uterus are side effects of having babies, that they are things one gets over and walks around with. I challenge any man to walk around for a couple of years with a prolapsed anything and not to stand outside the gates of Leinster House holding a placard referring to his bits and bobs.

I wish to refer to what Deputy Bernard J. Durkan said about benchmarking. Recently in respect of the Civil Service it was mentioned that there should be a Dublin weighting or that an extra allowance should be paid to those who worked in the city. It is normal for staff who work in the National Health Service or the private sector to receive extra money to meet the higher rents and greater expenses associated with living in the city of London or urban centres in the United Kingdom. It is no good wringing one's hands and saying a weighting system could not be introduced for a midwife, a nurse or even a person who is training to be a doctor. It is not possible to commute from Tyrrellspass to St. James's Hospital. That is no way to start one's day or live one's life. We must adopt a multifaceted approach to make working in maternity services attractive.

I thank the Chairman and delegates for their patience.

Chairman: Members have asked a number of questions. Perhaps the delegates from the INMO might comment again.

Ms Phil Ní Sheaghdha: My colleagues and I will address some of the staffing issues first. Ms Leahy works in Our Lady of Lourdes Hospital and will give an overview of its nurse-led unit and audit mechanism.

On recruitment and retention in general, Deputy Margaret Murphy O'Mahony asked what would fix the problems. The measurement we have used in our submission to the Public Service Pay Commission is purchasing power parity, in respect of which we took into account the cost of living and earning potential. For example, the average staff nurse earns between €28,900 and €42,000 over a timespan of nearly 20 years, which is very modest pay. Student nurses do not earn an income; they only receive the minimum wage of just over €9 an hour during their 36 weeks of training. In some cases, they must pay for two units of accommodation because their clinical placement is completed in two separate locations. These aspects must be corrected to make nursing an attractive proposition and counteract the reduction in the number of applicants. Of course, the cost of living has got a lot to do with the reduction in the number of applicants.

On purchasing power parity, we know that health services in the United Kingdom have always been a huge fan of the Irish trained midwife and nurse. That is going to become increasingly attractive. Our market is going to become increasingly attractive. Weighting in London adds about 21%. That is not confined to London, however. It applies in any major city, including Manchester and Bristol. Great Ormond Street Hospital comes to recruit our paediatric nurses immediately on qualification, and it succeeds.

We know all of this, as do the Government and the party of Deputy O'Connell and Deputy Durkan. We have made numerous submissions to them. I would argue that it is now within those Deputies' gift to correct it, and I urge them to do so. Paying people €28,900 and expecting them to be exposed to what Dr. Boylan described cannot continue. There will never be a developed maternity strategy unless the Government bites the bullet and corrects the salary of low-paid women. I emphasise that they are predominantly women. There are four male midwives in the country according to the last count. Nursing is not very different. We can talk around it, but the simple fact of the matter is that we have overcrowding to such an extent that there were 640 patients on trolleys on Monday of this week, for whom there are no beds. Absolutely every non-urgent elective case must then be cancelled. We are not dealing with the reasons the beds are closed.

Yesterday I spoke to somebody in the HSE who says that the Minister has announced 540

new acute beds. We welcome that. Several of them will be opened based on the beds that have been closed. Where will the health service get the staff to open them? It cannot open beds and not recruit staff. It all goes back to the same central point. People must be paid properly for what they are expected to do and what they are exposed to. The levels of burnout and the levels of assault in midwifery have increased. These issues are all related and come back to the same circle of recruitment and retention. We have provided the figures. They are the HSE's figures. There are 16 fewer midwives working in the front line today than there were on 16 December. That is despite recruitment measures, including recruitment from Portugal and Italy. We are battling in recruitment, entry and retention. Somebody has to do something about it, and we urge the Government parties to do something about it. It is within their gift.

In respect of the inquiries, it is important to emphasise what happens when an adverse incident happens, particularly in the HSE. The first thing that happens is an oversight investigative process is put in place by the employer. The practitioner is called to that as a witness. Senator Burke asked what supports are available. More often than not, the practitioner is then subjected to a Health Information and Quality Authority, HIQA, investigation. The oversight investigative process which the HSE conducts usually looks at the learning outcomes. It is not supposed to apportion blame, but we know that there have been incidents where blame has been apportioned. The practitioner is then subjected to a HIQA inquiry. In the case of nurses, midwives and medical staff, a statutory body becomes involved. This is a separate process. In many instances, a disciplinary procedure is instigated by the employer in addition. For instance, there may be a coroner's inquiry, which involves An Garda Síochána

A speaker was absolutely right to note that the employer does not support any staff member going through that. In the main, it is their trade union that supports them. We have specific insurance policies for our members who go through this. We pay their legal fees and the cost of their counselling services, and we are constantly saying to the employer that this situation is not good enough. We are happy to do it and happy that our membership covers that cost. However, without their trade union they would have absolutely no support in many instances.

I am glad to have been asked the question as it gives me the opportunity to set the record straight. It is one of the respects in which our midwives in particular, who have been through a number of inquiries in this country of late, are very critical of their employer. Some of them have been followed to their homes by journalists. This should be anticipated. When a practitioner is undergoing an inquiry, there should be a separate room for them, with a separate exit by which they can leave, so that they are not identified. We should not have to go before the Nursing and Midwifery Board of Ireland to argue for an *in camera* hearing. The employer should be quite willing to agree that this takes place. Ultimately the staff member will be found not to have been professionally questionable, but it will not matter, because the media has destroyed their name in the process. It is a very serious issue, and one that is readily rectifiable.

Dr. Boylan referenced the Australian system. We have had years of Ministers talking about other services. When he was the Minister for Health, Senator James Reilly said that we need the system of health care that they have in the Netherlands. We have had years of this. We cannot transplant another system into our own when we have absolutely no primary care development and our outreach maternity services do not exist. In particular, we cannot transplant a system into ours until we develop the community services in the first instance. That is one of the areas where nurse advancement and midwifery advancement have particularly helped in other jurisdictions. I refer to advanced midwifery practice in smaller units. There is a very important place for the advanced midwife practitioner. This practitioner would be a constant staff member

in a certain location, very well-practised and very skilled in the area of infant and mother care.

I want to make a point in respect of the clinical nurse specialists, CNSs, referred to by Mr. Kilian McGrane. I refer to the numbers mentioned and the funding for the posts, the sum of approximately €4 million. I have calculated that 82 posts are at issue. Each one of those clinical specialists will come from the pool of midwives that are currently working. They are not new posts. Most of them are uplifts from the current posts. That means we will lose 82 current posts unless we agree to backfill each one of the clinical nurse specialist posts.

We have spent the last two weeks talking to the HSE about the funded workforce plan for 2018. There is no mention of backfill for maternity posts in that strategy. We urge both the HSE, which is represented here, and the representatives of the Government party to carry our message to the Department of Health and to the Minister. There is absolutely no hope that this strategy will be implemented unless each CNS is backfilled and we have a plan for the development of advanced practice in midwifery. We know that the latter works, because in jurisdictions where it is in place, it contributes massively to the service provided for women across gynaecology and obstetrics.

Ms Mary Gorman: In regard to the midwifery-led unit, MLU, a committee member asked about audits and about how it was perceived. I am lucky enough to work in a unit that has one of the two midwifery-led units in the country. Research into the MedU trial showed that the outcomes for women were comparable with the same population within the consultant-led unit, but that women valued the experience more within the MLU. Internationally, it is recognised that they are as safe within that group of women, if not a bit safer. It is recommended as a way forward. Furthermore, there are ongoing audits within the unit, so they are audited in the same way as the consultant-led units within each of the units.

Deputy Kate O'Connell: Are there proper scanning facilities in those two centres?

Ms Mary Gorman: No.

Deputy Kate O'Connell: Is that not a concern?

Ms Mary Gorman: It is a concern, and we have done our best to address it. Hopefully this will be resolved in the timeframes that Mr. McGrane described. However, it is a matter of training people, because recruits are not available. We cannot recruit people to scan, so we have had to train our own.

Dr. Peter Boylan: With regard to the recruitment, it is not the case that there are 100 consultants who could be recruited to the service tomorrow. A figure of ten consultants a year is realistic over ten years, plus replacements. They are not there, and we cannot train them quickly enough. We do not want to appoint people into consultant jobs if they are not ready for it. That has been a big problem in the UK, where significant numbers of consultants are on gardening leave because of problems with their practice. We need to be careful to do it properly.

As we have heard, outcomes in Irish obstetric care are very good by international standards. That is in spite of, rather than because of, our staffing. It is also important to replace those who retire. This means that in addition to hiring ten new staff members, we must also replace outgoing staff members. Many people talk about the airline industry when they are making comparisons with safety. I do not think passengers would be happy if someone came over the intercom prior to take-off to explain that they are being flown by a trainee pilot who has been recruited because the regular pilot is unfortunately on holidays and to express the hope that as

the trainee pilot has almost finished his or her training, everyone will get there safely. That is what happens in our sector.

The two trainees who left had exit interviews to see what the problems were. That is reflective of the pressures of the specialty. It should be pointed out that people leave surgery or paediatrics etc., to go into general practice when they realise that what they are doing is just not for them. It is good that they leave because we do not want people going through a training system, being unhappy at the end and then working in a system in which they are just not comfortable.

A question was asked about a lack of oxygen during birth. Birth is a hazardous process. That is why so much attention is placed on it. Advice is always available. Midwives always have the authority to go over the head of the junior doctor on call to the consultant on call if that is felt to be necessary. That should be welcomed and should be standard practice in every unit. That was certainly the case in any unit I ever worked in.

There has been no mention of Article 40.3.3°. The article has not been repealed. I guess things will change when and if it is repealed. Obviously, the institute will be available in terms of training doctors in relation to performing terminations. In the majority of countries where this is widespread, it is done in the community at less than ten weeks, and there is also the medical termination of pregnancy and the tablets we have heard about which are currently being imported. Obviously, that is something that would be addressed between ourselves and the community services etc.

It is blindingly obvious that folic acid should be in food. We should just get on with it. I understand there is some kind of problem with the importation of flour from England to make bread in this country. All these problems should be overcome.

I believe Dr. McKenna will talk about gynaecology. I suggest that a modification of the mastership model, along the lines of the development that is happening in the South/South West hospital group, represents the way forward for governance. I emphasise the real importance of having separate governance and a separate protected budget for women's health care, including maternity and gynaecology.

Reference has been made to the Australian system. I acknowledge one cannot import an entire system but one can import bits of it. Obviously, we would not do exactly the same things as Australian doctors. I think this is something that should be looked at from a specialist point of view when we are encouraging recruitment and encouraging doctors to stay in the Irish system.

Senator Colm Burke: Do we have an idea of the number of consultants who will be retiring over the next five years?

Dr. Peter Boylan: I cannot give that number off the top of my head, but it is very well known.

Senator Colm Burke: We want to create a number of new places in addition to replacing the people who are retiring. Will we have a sufficient number of people to meet the target?

Dr. Peter Boylan: Probably not.

Dr. Peter McKenna: Can I make one or two comments before the director answers for himself? I thank Deputy Durkan for his question and his incisive observation about the recurrent problem of the deprivation of oxygen. We hear that the maternity services - benign gynaecol-

ogy - consume between 2% and 3% of the health care resources of this country. On the other hand, we contribute to 60% of the payouts from the courts as regards medical negligence and compensation. There is a huge disparity between the resources we have to work with and the justifiable expectations of patients as regards adverse outcomes. Without commenting on the generosity of the awards, I will say that the courts will only award money in the event of what they perceive as being negligence. These are preventable, or potentially preventable, issues. We have set this as one of our targets for reduction in the coming years. It is estimated that it is possible that 50% or more of the more tragic cases could have been avoided with different action. I thank the Deputy for drawing attention to this area, which we are very conscious of trying to rectify.

Deputy O'Connell asked about benign gynaecology. We recently visited Castlebar, which is one of the more difficult places to get to for those who are based in Dublin. We were phenomenally impressed by the quality of the gynaecological service there. The gynaecological clinic there has all the facilities needed for it to run on the spot. Ultrasound is available in the clinic, which means one does not need to make an appointment to go to have an ultrasound and then come back. Hysteroscopy is available there on the spot. One can have a hysteroscopy and possibly have some endometrial pathology removed if one needs it. This is possible for two reasons, the first of which is the availability of the medical champions who want to do it and the second of which is the presence of an administration that prioritises it and allows it to be done. That is what I mean by an imaginative approach.

Mr. Kilian McGrane: I will keep my comments brief and will focus on areas that have not been touched on already. Senator Burke asked about the gynaecology service in Cork. I am sure he is aware of the plan that was developed last year. Approximately €1 million was invested in Cork University Maternity Hospital last year to try to address that. The hospital hit its target of 1,500 new patients last year, which was a very positive development. The additional resources that are going in are not as much as the hospital authorities would like, as set out in the original plan. Approximately 50% of what they were looking for is going in this year. We will work closely with them to try to address that. It is not going to address it in the short term. There will be a phased approach. We will require our strategic plan for gynaecology to be developed to say that we have set targets. It is only when we set targets and resource the institutions to deliver on those targets that we will make meaningful progress.

Senator Colm Burke: Has the waiting list decreased?

Mr. Kilian McGrane: The hospital met its target of 1,500 patients last year. I am not sure what has gone on, or what has been accrued, during the same interval. The hospital hit those who had been waiting for the longest period of time, in line with the target in the plan it has put together.

Senator Colm Burke: Would it be possible for Mr. McGrane to come back to me with those figures?

Mr. Kilian McGrane: Sure. I would be happy to come back to the Senator on that. He asked whether there is evidence that staff in any location are more likely to leave than staff in other locations. We do not have any evidence of that. We do not have any location where there is a haemorrhage of midwifery staffing, or consultant staffing for that matter. It would be something that we would expect the hospital groups to identify in the first instance. Obviously, if we became aware of it, we would follow up on it.

Deputy Durkan asked a number of questions specifically of the director. We do not have responsibility or accountability for either posts and undergraduate training courses. It is something we would hope to influence rather than have direct accountability for.

Deputy Bernard J. Durkan: Who does have accountability for it?

Mr. Kilian McGrane: Within the HSE, there are separate units for midwifery training and development and for medical education and development. There is a dedicated unit in the HSE for education. It deals with medical education separately from nursing and midwifery.

Deputy Bernard J. Durkan: And there is another one for development.

Mr. Kilian McGrane: It deals with education and development. I cannot remember its exact title. We will come back to the committee with the specifics. Our colleagues in general midwifery and through the institute would identify if there are requirements for change. We would have a role in that but it is not our area of responsibility.

The Deputy also spoke about risk factors. I think we are all very aware of the points raised by Dr. Boylan about on-call and weekends. I totally agree that they need to be addressed. Dr. McKenna spoke about hypoxia and the risk factors and this is our focus of attention. We mentioned in our opening address our draft instant management framework that sets out a process by which we would hope to standardise even the reviews of these cases. This would have a number of advantages, including the lessons that would be disseminated. It would be the responsibility of the programme to ensure that lessons from an incident in an individual location would be disseminated nationally. That responsibility falls on us.

In terms of the adequacy of the programme's resources to discharge its responsibilities, there are two separate elements. Each individual hospital is accountable for what it delivers. We spoke about the mastership. The masters are responsible for the services provided in their institution. The programme could not possibly do that remotely. At the moment, we have the resources that we have been given. We could probably have spent a little more but not a hell of a lot more. We sought in the region of €14 million for development funding for the programme. That is a full-year cost. If we got €7 million, that is probably the very most we could have spent in a year. Colleagues in both the institute and the INMO have highlighted the recruitment challenges. Therefore, the sum of €4.55 million is probably not far off the maximum we could have expended in a year in terms of staffing levels. We are satisfied with what we have. It will be up to us to demonstrate that it is used effectively in order to attract additional funding next year.

I note Deputy O'Connell's point about "person" rather than "woman". She mentioned the issue about terminations, which was outside our control. If there is a repeal and legislation is passed, it will be up to us to size its implications for the service, subject to there being a surgical impact. The risk is that there would be an impact on gynaecology waiting lists if surgical procedures are required.

The midwifery led unit, MLU, has been addressed, as has foetal folic acid.

I appreciate Deputy O'Connell's point that we should get them now if we are short 100 consultants. The proposal of both the institute and the clinical care programme was that we would invest in ten consultants a year for ten years. We could stretch to nine this year although we would like to have had more. As Dr. Boylan said, whether we would have got them is not 100% certain. It is a positive message to say that we are investing in maternity services and it is to be hoped that that will attract more people into the training programme.

We have covered the on-call issue.

Deputy O'Connell responded to Ms Dunne's observations about the public confidence. Our experience is that public confidence gets hit regularly. We have regular adverse media coverage. As recently as last Monday, it was on the foetal monitor issue. We then get feedback from the institutions stating that women are coming in and asking whether the monitors are safe. We know there are challenges with cardiotocography, CTG, interpretation but that is not an issue that is specific to the monitor; it is a training and development issue. We are very concerned about that public trust and confidence. We want women to avail of the supported care pathway. We do not want them to feel they must have multiple scans outside of what is required and access to an obstetrician every time they come in because their confidence in the service is impacted. That is a big concern from our perspective.

I fully accept what Deputy O'Connell said about anomaly scanning, both the challenge for staffing and the upskilling. The number of 28 is what the system said we need and hopefully we will get most of them this year. Some of them will come in on a training programme which could take up to 18 months. That is why we are saying it is likely to be the end of next year before we have everything that is required.

On the mastership, and Dr. Boylan has referred to this as well, as the voluntary hospitals in Dublin are individual institutions, they are not part of the HSE. They therefore can appoint a chief executive officer, CEO, or, in their case, a master who reports to the board. In a HSE context, it is different. There is only one CEO or director general and currently there is not a board but a directorate. As I said, the South/South West group appointed an executive clinical director and that kind of model would work very well.

I acknowledge what Deputy O'Connell said about budgets. We have to be careful though. In a stand-alone unit, the budget needs to be separated but if it is part of a large general hospital such as that in Wexford, Mullingar or Kilkenny, it takes 4% or 5% of the gross budget. If we start pulling those budgets out, the maternity directorate within it would then be responsible for portering, cleaning etc. In a hospital of that size, it may not be feasible. We therefore have to come up with a hybrid which does exactly the same, that is, it protects the resource, which is our key bit. We cannot come up with something that is not workable in a unit that has maybe 1,500 births in a very busy hospital. There is a collegiality aspect. Radiology, pathology and all of the other facets have to work together. We do not want to break something that works but, at the same time, we want to respect that governance and protect the resources that go in.

We accept the point Deputy O'Connell made about co-location. I will not comment on the issue of men outside with prolapsed anything but I take the point that we take the gynaecology issue seriously.

Chairman: I call Ms Mary Leahy.

Deputy Bernard J. Durkan: Before that, what about the chain of command? It is very important. The two-way process-----

Chairman: We will let Ms Leahy come in first and we will come back to that issue.

Ms Mary Leahy: I will make two or three brief comments. The first relates to item No. 7 of the list of actions which were to have commenced by the first quarter of 2018. This was that "additional supports are provided to pregnant women from vulnerable, disadvantaged groups or ethnic minorities, and take account of the family's determinants of health, e.g. socioeconomic

circumstances" and the action to be taken was to develop a plan to support vulnerable women and families antenatally and women, families and infants postnatally in conjunction with the local socio-economic inclusion team. Speaking as a practising public health nurse, we see more and more homeless pregnant women and mums. A lot of families are in hotels and we are noticing obvious negative health effects. New babies and toddlers are not achieving the milestones expected of their age because they are living in hotels and accommodation that is inappropriate for young families. This is a serious issue that is becoming commonplace and I do not see any actions in respect of it. I wanted to raise that issue.

I want to hone in on what Ms Phil Ní Shéaghdha stated. This strategy sought the recruitment of 96 midwives per year by five years but we are more than one year into it and not alone have we not recruited the 96 midwives but we have a deficit of 16, which could be interpreted as a deficit of 112. This strategy cannot be implemented without the recruitment of midwives. All of the Deputies and Senators raised the issue of why and we spoke about pay and other conditions, but it is a chicken-and-egg scenario. If we do not pay people properly, we will not recruit and if we do not recruit, the workload is phenomenal and there is a massive burnout and demoralisation in the workplace as a result.

Let me say to members, as politicians, that it is no longer possible to preside over a system which pays nurses and midwives between 12% and 20% less than every other four-year honours degree graduate. It is a disgrace. We ask if it is because we are predominantly female or that the Government has got away with it too long. We have asked so many questions but the time has come where this cannot be allowed to prevail. As a first step we are seeking parity with colleagues who at entry level have a four-year honours degree.

The issue of risk was mentioned as well. All of the international research shows that the risk of mortality and morbidity rises substantially for every one less nurse or midwife on a shift or ward. That in itself is a risk. We aspire to one midwife to every 29.5 births when we are nowhere near it. We are between 1:35 and 1:40. As a public health nurse in the community, I can tell members that we are severely short on public health nurses as well. The lack of midwifery in public health was mentioned. This is correct. It has been replaced by a family and child module. This cannot be compared to being a qualified midwife. An audit has not been done on it but we are noticing a deficit. It is another issue and I am glad it was raised. A module cannot be compared to having a postgraduate qualification in midwifery or a direct entry qualification.

Finally, I will refer to my medical colleagues, the issue of goodwill and the fact that the unpaid-for hours is definitely an issue in medicine. It is a massive issue in nursing and midwifery as well. We have proved that through auditing our hours. We are giving massively of free hours in midwifery and nursing and that goodwill is not sustainable.

Chairman: I will allow Deputy Durkan a short question.

Deputy Bernard J. Durkan: It is not a short one; it is a fundamental one. It relates to the chain of command and the free flow of information in both directions, that is, how the director responds. If a person is directing maternity services in the country and there is a glitch somewhere in the system, he or she needs to know about it. He or she also needs to do something about it. If he or she cannot do something about it, we need to know why - apart from money, which is one of the things that comes into it all the time. The people on the ground who are at the coalface need to have confidence in the reporting up along the line. Hence, the chain of command is hugely important.

Mr. Kilian McGrane: I thank Deputy Durkan for clarifying the question. As I just stated a moment ago, it is important to state that the programme is not clinically responsible for the delivery of the service in any individual unit. It would not be feasible or practical. Our role is in monitoring, oversight and design of the system. It is slightly different from the normal chain of command. If something does not happen in an individual institution, it is a matter for the master of a maternity hospital or the general manager or the CEO of a general hospital. If we were to separate them, we would make it impossible to deliver quality services. My two colleagues who have worked as masters would also say this and I have been the CEO of a hospital. If somebody sitting outside the institution was to take accountability, the system would break down. However, it is exactly as has been said and we must be notified when issues emerge. We can add real value when the design of the maternity networks means that individual units no longer just look at their own practice; it is looked at in the context of others. If we take a hospital group such as Saolta which has five units, it compares data across the five units. We then meet it and compare its data with those for the other five maternity networks in the system. In that way we hope to start to identify an emerging trend because it may not be a trend in an individual unit or even a group but it may be across the country. That is where we come in. It is the ability to provide scrutiny at local, network, group and national level that will provide a different approach to how the service is managed. That is what is set out from a governance and leadership perspective in the maternity strategy and it is what we aspire to do. We have to have real-time information to be able to provide it.

Dr. Peter McKenna: Very briefly on the question of terminations, it is not just a belief or an ethical base, as from our point of view it has resource and very practical implications. In the United Kingdom approximately 700,000 babies are born a year, while there are approximately 180,000 terminations. For Ireland, we could possibly divide each of these figures by ten to get a guesstimate. In the United Kingdom 60% to 70% of the 180,000 terminations are carried out medically, not surgically; consequently hospital admission is not required. By any estimate, 40% of terminations will possibly require a surgical intervention which will have considerable resource implications for gynaecological services. In our interest to deal with the ethical element I am concerned to ensure the practical implications will not be overlooked.

Senator Colm Burke: I want to ask Mr. McGrane about the provision of support for staff where there is an adverse event. I outlined an incident where staff were required to attend an inquest without support of any description prior to doing so.

Mr. Kilian McGrane: I will ask my colleague to come to that issue in one minute. Dr. Boylan used the term "second victim"; it is one that is increasingly becoming common.

Ms Angela Dunne: When an incident happens, there is a debriefing locally. There is a HSE policy. There is also the provision of employee assistance. Our colleagues in the INMO are very supportive of our staff and help them when drawing up their statements. It is very difficult when an adverse event happens. This is where the directors of midwifery come in. The level of support for their colleagues is huge. This does not just go on for one or two months; it can go on for two years, while all of the investigations are being carried out. It has a huge impact on recruitment because when someone is working alongside colleagues, he or she sees that they are quite distressed as a result of an incident occurring. There is a huge amount of work to be done on this issue.

Community services were mentioned. One of the issues at which many maternity units is looking is the transfer home. The level of postnatal dissatisfaction is very high during the first ten days after a mother leaves hospital. There are some very good practices throughout the

country, where for the first ten days midwives go to support mothers. This just does not happen for those who are at low risk but also for those who are high risk. There was a tendency originally when the service started to visit mothers who were low risk, but ladies who have had a caesarean section need more support. I want to make the committee aware of this.

Deputy Kate O'Connell: I want to pick up on Ms Leahy's comments on children living in hotel rooms. Anyone who has reared children can only imagine that it is not good for them. For the sake of the committee - I know that Ms Leahy does not yet have hard data - will she outline for it the milestones being missed? I am very familiar with the tests children go through, but will she outline them for the committee? Does she have any knowledge of the knock-on effect once children start school? I argue that such children start one mile behind mine. Will they ever catch up? For the sake of the committee, will Ms Leahy outline her experiences? Clearly, she is very experienced in this field.

Ms Mary Leahy: I meet families postnatally. We receive notification of a birth; we know within 24 hours that a birth has occurred and that the family are homeless. Invariably social services are involved in the internatal stage, but we do not see any evidence of social work community support postnatally. The mother will have some connection with the maternity hospital whereby she can access a social worker for a period of time, but it is very brief. We do not really have social workers in the community. There is also a shortage of public health nurses.

On how it affects families, initially the mother and the family endure understandable psychological distress at the fact that they are homeless. There is a sense of shame and failure and all that comes with it. Very often, they are placed in a hotel immediately after birth and would not necessarily be in the same hotel they were in antenatally. They are moving into a completely new environment immediately after having a baby, which brings its own risks. It is a high-risk period for any mother after delivering a baby. Very often, the hotel is located in a geographical area not known to the family. In addition, we are noticing a massive nutritional and dietetic effect because in the contract with the hotel the accommodation paid for by the HSE is possibly on a bed and breakfast only basis. We notice that the family are given a fry every morning, but there is no provision for an evening meal or dinner. We also notice that mothers are relying on commercial foods for infants and baby rice in jars with no provision of facilities to heat them. We are getting involved in negotiations with hotel staff to see whether they can swap a breakfast for an evening meal which is more nutritious. A breakfast could be cooked in a room. Porridge is easy to make and more nutritious than a full fry every morning seven days a week. We are involved at this level of negotiations to try to do a deal with hotels in order that families can eat better because there are massive implications in terms of obesity, poor child nutrition and socialisation associated with diet and eating.

Another issue I have seen is that gross motor development is delayed in infants because mothers, understandably, do not want to put them down on the carpet in the hotel room because they do not know how long it has been in place and who has been on it before them. We are encouraging them to get more towels to leave them on the floor to let the baby down on the ground to move and achieve the milestones expected at the various times we assess babies such as at two weeks and three months. We notice that speech and language and gross motor development are delayed. We also notice psychological distress in the mother which invariably impacts on the rest of the family. We also notice nutritional, dietetic and psychosocial effects. It impacts on the networking supports of which the families could invariably avail if they were living in the community. Very often, they are moved to another hotel or temporary accommodation after a period of time such that they are not able to develop the supports available. This is becoming

very common. Two years ago it was rare, but now I see it regularly and I am covering an affluent area. It has nothing to do with the socioeconomic group being covered but with where the hotels are located.

Deputy Kate O'Connell: I assume the breastfeeding rate is very low, given the associated stress.

Ms Mary Leahy: Absolutely.

Deputy Kate O'Connell: There must be huge hygiene issues in washing bottles.

Ms Mary Leahy: Massive.

Deputy Kate O'Connell: I cannot even think what it is like if someone has a two year old and a new child is roaring. I used to go out the back sometimes just to get a little peace.

Ms Mary Leahy: And breathe.

Deputy Kate O'Connell: I am thinking about where someone would wash and dry bottles and even the risk of the kettle falling. It is no way to rear children. I thank Ms Leahy for her comments because I do not think the issue has ever been brought up at the health committee. To sum it up, the outcomes for a portion of a generation of children are being adversely affected.

Ms Mary Leahy: Absolutely.

Chairman: I have a few comments which I will address to each of the groups. In his opening statement Mr. McGrane mentioned the importance of audits. Is there a difficulty in collecting information across 19 maternity units to have proper information and engage in planning? Perhaps the models of specialist care, assisted care and supported care and how they differ might be outlined. It was also mentioned that there is a quality and safety manager in each unit and a serious incident management forum. Do they exist at the moment or are they planned? In respect of Dr. Boylan and the governance model, the opening statement referred to maternity leads, if they do not have authority, not being held responsible or that they should not have the same level of responsibility. I presume that compares the mastership model to other models. Perhaps that might be expanded upon.

If our maternity hospitals become co-located with general hospitals, as is planned over the next number of years, will that lead to better working conditions and improve the ability to recruit and retain staff? Will that be a factor? What are the differences between a midwifery-led service as opposed to the standard service? Dr. Boylan referenced a possibility of conflict between doctors and midwives in his opening statement, depending on the model of care and in particular the supported model of care.

I also refer to open disclosure. We are looking at open disclosure legislation in the Oireachtas and a Bill is going through at the moment. Would open disclosure in a timely fashion decrease the number of cases being taken? It appears information is very slow to come out in relation to adverse incidents and timely open disclosure may obviate litigation. Should there also be a mandatory inquest into all maternity deaths? Again, legislation in the Dáil proposes that this would be the case, which does not seem to happen at the moment.

Mr. Kilian McGrane: Could I take the last point first? There should be mandatory inquests in all maternal deaths. At the moment, an inquest is discretionary and this year there have been several cases that have not had post mortems where I think it would have been of benefit to the

system. For the few maternal deaths there are, only between five and seven a year, the added workload in terms of the number of post mortems necessary would not be very big. In order to complete the information a mandatory post mortem in the case of a maternal death should be necessary. A very clear "yes" to that.

Chairman: What about the models of care?

Ms Angela Dunne: There are three models. The supported model, the assisted model and the specialised model. Each of those is based on the risk assessment of the woman, whether she is low risk or high risk. The supported model of care is usually provided by midwives who are experts in low risk women. The assisted model is a combination of consultant care and midwifery care. Specialised care is for the very high risk mother.

In respect of the point raised about midwives and the consultants, midwives are required to deliver all three pathways of care. Many midwives are expert in the supportive model and want to work in that area. However, we also have to provide midwifery care to the assisted and the specialised models. That is the point referred to earlier I think.

Mr. Kilian McGrane: On the issues raised about audits and data, at the moment we have good systems for data collection. We have the Irish maternity indicator system, IMIS, which consists of 37 collated metrics. It was annual. We have produced a half-yearly report and hope to have the 2017 report by April or May. That was developed first by our colleagues in the clinical care programme. We also have maternity patient safety statements published monthly. We have four sites live on the maternal new born clinical management system. Our data collection systems have got significantly better and are allowing for some comparison.

Dr. Boylan talked about audit. We very much support that. We are starting to be able to look at that. There is also the national perinatal epidemiological centre in University College Cork, UCC. It does good work in analysing a variety of different suites of metrics that come out of our maternity services. That data is much more research-based and comes out 18 to 24 months after the year in question. We are looking at capturing information that can affect decision-making closer to real time. The IMIS system will allow us to do that.

The model of care has been covered. In respect of quality and safety, we are providing funding for each maternity network to appoint a manager. One group has led the way in the serious incident management forum. The Royal College of Surgeons in Ireland has its forum set up. It has a group of specialists who look at maternity-related incidents. It allows for a more focused conversation. My colleague, Dr. McKenna, has been chairing that group for some time. He can talk to the specifics of it.

Dr. Peter McKenna: The important features of it are that maternity incidents are reviewed by a multidisciplinary team and that team would be midwifery, obstetrical and people associated with delivering the service such as risk managers, anaesthetists, and paediatricians. The core of it is each hospital does not necessarily review only its own cases. There is outside assessment. Hospital A will present its cases and hospital B will have the ability to comment. The idea that each hospital can learn from the other is inherent in the system. These are the fundamentals.

Chairman: What about open disclosure?

Dr. Peter McKenna: Open disclosure is encouraged.

Chairman: Is it practically applied?

Dr. Peter McKenna: In my experience, mostly it is. It depends on how an adverse outcome is interpreted. There are several interpretations. When a case goes to court we hear two very different sides to it. Open disclosure may present a certain number of facts but they may not be entirely the same as if somebody else looked at it. However, they are true to the person presenting it to the patient.

Senator Colm Burke: On open disclosure, where it is decided to have an external review, can the open disclosure occur before the external review is carried out?

Dr. Peter McKenna: Ideally, open disclosure should occur within the first couple of days of the adverse incident. It should not wait until any review is done. The clinicians should explain what happened, where it went wrong and their perception as to why it went wrong.

Senator Colm Burke: However, occasionally there may be a situation where they do not have all the answers.

Dr. Peter McKenna: Then they cannot tell. If for example there is a post mortem, then that has to be awaited. If the post mortem is ordered by the coroner then some coroners will not let the findings from that be used until the inquest has been concluded. That could be six, 12 or 15 months later.

Senator Colm Burke: On the issues of external reviews and fast tracking, I have come across cases where there has been quite a delay in carrying out the external reviews. Has any process been put in place to try to have those done in a timely manner?

Dr. Peter McKenna: The way external reviews are done now does not work. The patient advocacy groups are advising patients not to participate because it takes so long and the language is so tortuous that sometimes it is not worth the patient's while getting involved. There is a new review system within the HSE and we will be working along with that to make information available in a more timely and structured manner for patients who suffer adverse outcomes.

Mr. Kilian McGrane: That is a good point. The learning has been taken onboard by the HSE. It has a new incident management framework with a tiering. What was described as a systems analysis review was at the top end. However, there were only one or two steps before that. Once in that process it is extremely formal and does take a long time. What the HSE has come up with is a multiplicity of different approaches and there is an attempt to pick the right one to meet the needs of the family involved in the care. We can try to move away from a system where there is a need to wait for what could be a two year process to find out the answers and try to do it in a much more timely fashion.

Chairman: Will Dr. Boylan address the issue of clinical governance?

Dr. Peter Boylan: On clinical governance, the model that is evolving in the south-south west Cork area is probably the best one. On the point I made about authority and accountability, it is not fair nor does it work to hold people accountable if they do not have the authority to fix things that they perceive to have gone wrong. It is not right to hold somebody accountable if something goes wrong over which he or she has no control. It is not any way to run it.

Chairman: Is it easier in the mastership model?

Dr. Peter Boylan: Yes. The mastership model is crystal clear. The master is responsible for running the hospital in a corporate sense. He or she has overall responsibility. The master

cannot be responsible for every single thing that happens but is, in a corporate sense, responsible for everything that happens in the hospital. That includes the financial management of the hospital. The master is not an accountant and does not have huge financial knowledge but is responsible for it. He or she has people to help, such as accountants and financial managers and so on. It is the same way with the administration, midwifery and nursing side of things. There is a director of nursing and midwifery who is responsible for that. All those people report to the master. If one is running a ship, one needs a captain. If one is running a team, one needs a captain. There has to be one person who is responsible and accountable and has the authority to do things. That person reports to the board. The master is accountable to the board, which owns the hospital in trust. The board does not have any financial interest in the hospital but owns it in trust. It is a good system and it works. The board system in the maternity hospitals works because there are people from different backgrounds - legal, financial, property and so on - who are there *pro bono* to give advice on the running of the hospital. It is a system that could be introduced in some way into HSE hospitals and into the hospital groups and networks. The board is made up of people who rotate and do not stay on it forever.

Will co-location improve conditions? It probably will. It will certainly improve the conditions for the mothers, women and persons coming through the hospitals. That is very important. It is important to understand that the traditions and *esprit de corps* in the stand-alone maternity hospitals in many of the units around the country are very important and sometimes that gets lost in a new building. It is an important thing to consider. If the conditions improve, retention will be easier. I made reference to the importance of avoiding conflict with midwives in developing the three models of care and made reference to places outside the country. What I was referring to was the mid-Staffordshire Morecambe Bay problem where a group of midwives were working very much on their own and achieving normal birth at any cost. Unfortunately that cost worked out to be the death of babies and mothers. It is really important we make sure we continue the good tradition of midwives and doctors working together in the Irish system and that we regard obstetricians as midwives who also look after more complicated pregnancies. That is the way to approach it. We have good relations and I hope they will continue.

The new office is a tremendously positive development and will enhance care. We have already seen some of the things being developed in the area of audit and quality and safety being very helpful.

Open disclosure means that one sits down with the couple or patient who has had an adverse outcome and try to explain what has happened. One may not be able to give a full explanation because, as Dr. McKenna said, one is waiting for post mortem results. One of the difficulties is that once it goes into the legal arena, there is a tremendous division and one is not allowed to approach the couple or the patient any more. That is a big problem. In that respect, mediation is a much better way forward in dealing with medico-legal cases than the adversarial way we have at the moment which is hugely expensive, time-consuming and awful for the patients and the couple involved. It is a nightmare for them. It is hard enough looking after a child with a disability but to have to go through all of that as well on top is terrible. All maternal deaths should have an inquest. That should go without saying. It is a statutory inquiry into what happened and I do not see any reason for arguing against it.

Chairman: I thank Dr. Boylan. We will move on to the issue of midwifery-led units and how they function.

Ms Mary Gorman: There are two midwifery-led units in the country. They replicate the supported care model within the strategy. The strategy recognises that every woman should

be seen by the appropriate professional at the appropriate time. There are a group of low risk women who choose to opt for this service. They see midwives alone depending on their risk as they travel through the pregnancy. The midwives are responsible for the antenatal, intrapartum and postnatal care up to seven days postnatally. There is a seamless transfer to obstetrics when the need arises and back if necessary. There is a really good working relationship between the midwives and the obstetricians. The goal is not a normal delivery at all costs. There is very good interaction and we are all part of the same governance structure.

Ms Angela Dunne said midwives are required in each stage of care no matter which pathway they fall into. Within our unit we transfer people between the labour ward and all around the unit so they have a good broad base. We all have ownership of the entire unit.

Chairman: What percentage are home deliveries?

Ms Mary Gorman: We do not offer that.

Ms Angela Dunne: Approximately 20% of all births.

Chairman: Approximately 20% of all births are home deliveries.

Ms Angela Dunne: Nationally.

Chairman: Are they private midwives who offer that service?

Ms Angela Dunne: No.

Mr. Kilian McGrane: They are self-employed community midwives. There are some private midwives as well. There are two hospitals that support a small number of home births, four or five a year. The self-employed community midwives are the majority and they work very closely with individual hospitals. It works well.

Ms Mary Gorman: I suppose they have a better understanding and it works very well.

Chairman: A point was made about the distinction between directors of midwifery and group directors of midwifery. Will the witnesses expand on that?

Ms Phil Ní Sheaghdha: I will take that question. Following on from the Portlaoise inquiry there was a recommendation that each of the 19 units would have a director of midwifery. Up to that point, many of the hospitals outside of the three Dublin stand-alone hospitals and the Cork co-located hospital did not have directors of midwifery. Directors of midwifery were appointed during those negotiations. We asked the HSE to implement the same structure that exists in the group structure. In that structure, there is a group CEO, a head of financial services and a group director of nursing. We asked that the same status be afforded to maternity services and that a group director of midwifery would be appointed. As Ms Dunne said earlier, it helps with reinforcing recruitment retention, policy, good practice and all the things that have been confirmed as benefiting the service from a leadership point of view.

A question was asked about whether co-location has assisted recruitment and retention. The only example we can look to is the Cork model. Right now the general and maternity services are equally as bad. One of the benefits is that a closer postgraduate education can be encouraged. Neonatology and ICU services can work more closely together and look at training modules that assist both. We have a huge shortage of midwives in neonatology units. That again comes back to an increasing requirement. With reference to what Dr. Boylan said

about the authority, currently, if one could describe our services as anything, it is that one has hospital groups which have the stand alone maternity services within each group which also has a separate governance structure. Likewise, one has general hospitals, voluntary hospitals, with separate governance structures. One has multiplicities of governance structures and it is very difficult to see where the authority lies. Our members would say regularly that we have all the responsibility but none of the authority and authority is the key. We need to know who is in charge and who is making the decision and whether they have fiscal control. One of the big criticisms that directors of midwifery bring forward is that, in many instances, they do not. They have all the risk responsibility but none of the authority to fire, to hire, to recruit and to make the service better.

Chairman: I have one final question and it is one we are grappling with in relation our Sláintecare report. What are the impediments to implementation? The national maternity strategy has been in place for two years now. Is it political buy-in, is it finance or is it a lack of understanding of what is being proposed? Where are the impediments to implementation?

Ms Phil Ní Sheaghdha: In my opinion, all those who work in the system view it positively. They believe it is the correct strategy. Therefore, it has to come back to funding. It has to come back to having an annual budget, but a ten-year plan. Every year, in October or November, one is making one's prebudget submission to the HSE and one may or may not get the money. That will dictate how much of the strategy one can deliver in the next year. It is not a capital plan. We are talking about a day-to-day spend. This year we went to the launch of the HSE's service plan and we were told that we were going to have to find savings of €320 million. How does that marry with a service modernisation and a service development? Yearly service planning is a huge impediment. One of the good things about the Sláintecare report was that it promoted multi-annual service planning.

Dr. Peter McKenna: I would have a slightly different perspective. There is more to it than funding that is an impediment. Let us take a mythical Athlone maternity hospital which was functioning on its own for many years but all of a sudden it is part of a group. It has to open up its practices to external scrutiny and it may not like this. In fact, one can be sure that it will not like it. The idea of being part of a group, part of a national strategy, does not necessarily sit that easily with individual organisations. I believe there is more to it than just money. There is the idea that a hospital is part of a system rather than a stand alone unit.

Mr. Kilian McGrane: If one looks at that in the maternity context, one can see some of those impediments because with the hospital groups, there is not a clear direction as to how they are performing, so they are all doing their own thing within reason. When one looks at the maternity networks, getting delegated authority, even within the HSE construct, is extremely difficult. What does delegated authority mean when it is provided? We mentioned earlier the issue about budgets. Does one separate budgets out on the basis of a clinical directorate model like maternity, or does one leave them embedded in the individual institutions? Moving from stand alone institutions into networks, whether they are clinical networks or governance networks, is problematic and the blueprint is not as clear for maternity. It is very clear that we have six and we are trying to work through that. We are encountering some difficulties as we move along but they are not insurmountable. When one looks at it on a broader scale, what is the infrastructure that will support the delivery of Sláintecare? Are the hospital groups and community health organisations, CHOs, aligned or not? Those questions are out there and in the absence of having clarity, people make their own decisions.

Chairman: On behalf of the committee I would like to thank the witnesses from the na-

tional women - or persons - and infants' health programme, Ms Angela Dunne, Mr. Killian McGrane and Dr. Peter McKenna; from the Institute of Obstetricians and Gynaecologists, Dr. Peter Boylan; and from the INMO, Ms Mary Gorman, Ms Phil Ní Sheaghdha and Ms Mary Leahy, for coming in.

This committee is adjourned until next Wednesday morning at 9 a.m. Is that agreed? Agreed.

The joint committee adjourned at 11.54 a.m. until 9 a.m. on Wednesday, 28 February 2018.