Report of the Committee Reviewing Maternity and Related Services in the North Eastern Health Board Area
Comhairle na nOspidéal

Report of the Committee Reviewing Maternity and Related Services in the North Eastern Health Board Area

July 2003

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EXECUTIVE SUMMARY

Maternity service provision encompasses an array of services and health care professionals to provide appropriate treatment for both mother and baby, including, inter alia, general practice, obstetric and gynaecological care, midwifery, nursing, paediatric and neonatal care and anaesthetic services, together with the range of required support facilities. Maternity services should support the mother, her baby and her family, with a view to their short-term safety but also their long-term well being. The care surrounding pregnancy and childbirth ought to take place in a safe, high quality and patient-centred environment.

Arising out of correspondence received from various bodies including the North Eastern Health Board, in early 2001, regarding maternity services at Monaghan and Dundalk hospitals, Comhairle na nOspideal, at its meeting on 28th February 2001, established a committee to review maternity and related services in the North Eastern Health Board area.

In pursuance of its task, the committee gathered as much detailed information as possible concerning maternity services in the North Eastern Health Board area. Simultaneously, the committee examined different models of service delivery, consulted with the relevant professional bodies and representatives of the health board and undertook a literature review.

In accordance with the statutory functions of Comhairle na nOspideal, the committee focussed on consultant staffing and related matters. However, in the context of the background to the request for the establishment of the committee and the Condon and Kinder Reports, the committee has made specific observations and recommendations on the full spectrum of maternity and related services, including the potential for midwife-led units, in the North Eastern Health Board area.

A SUMMARY OF RECOMMENDATIONS AS OUTLINED THROUGHOUT THE REPORT ARE AS FOLLOWS:

CONSULTANT STAFFING:
1. A total complement of nine consultant obstetricians & gynaecologists and ten consultant paediatricians is required to serve the population of the North Eastern Health Board (344,926). Since the establishment of the committee, and in line with the recommendations made, an additional two posts of consultant obstetrician & gynaecologist and an additional two posts of consultant paediatrician have been approved for the North Eastern Health Board, by Comhairle na nOspideal. The recommended total of 9 posts of consultant obstetrician & gynaecologist has now been achieved and there are 8 posts of consultant paediatrician in the NEHB.

2. One of the new posts of consultant obstetrician & gynaecologist should have a special interest in maternal-fetal medicine and this post should be based in Our Lady of Lourdes Hospital, Drogheda. This post was approved in April 2003 by Comhairle na nOspideal.

3. Adequate consultant anaesthetic cover for maternity care should be provided in Our Lady of Lourdes Hospital, Drogheda and Cavan General Hospital. Additional consultant anaesthetic staffing will be required as the maternity services develop and are enhanced in Drogheda and Cavan hospitals.
MODELS OF CARE:

4 An integrated model of maternity care should be provided in a hub-and-spoke fashion by the two existing centres i.e. Our Lady of Lourdes Hospital, Drogheda and Cavan General Hospital, to ensure that out-reach consultant provided, out-patient maternity, gynaecology and paediatric services are made available to women and children in the Dundalk and Monaghan hospital catchment areas. There is scope for developing similar out-reach services in Navan Hospital.

5 In accordance with professional advice received from the Institute of Obstetricians & Gynaecologists - which states that (i) the minimum staffing requirements to provide a 24 hour, 365 days per year (cover) for a maternity unit should be at least 3 consultant obstetricians with appropriate paediatric and anaesthetic services, and (ii) a viable maternity unit requires in the region of 1,000 births per annum - the committee recommends OLOLH, Drogheda as the maternity centre for the Louth / Meath Hospital Group and Cavan General Hospital as the maternity centre for the Cavan / Monaghan Hospital Group. The combined births in the year 2002 of 3,280 in OLOLH Drogheda, for the Louth / Meath Hospital Group and 1,300 in Cavan, for the Cavan / Monaghan Hospital Group, provides for two viable units. Together they facilitate a safe and sustainable maternity service to all residents of the NEHB area.

6 Regular and frequent consultant in-put should be made to both Dundalk and Monaghan hospitals, by the consultant obstetric & gynaecological staff and the consultant paediatric staff based at Our Lady of Lourdes Hospital, Drogheda in respect of the former and Cavan General Hospital with regard to the latter. The services provided at Dundalk and Monaghan hospitals should include out-patient maternity, gynaecology and paediatric clinics.

7 Due cognisance should be given to the professional advice received with regard to midwife-led units: The National Council for the Professional Development of Nursing & Midwifery has advised the committee that the concept of midwife-led maternity units in Ireland is at a very early stage and needs to be further developed and researched to ensure the correct protocols and guidelines are put in place. The National Council agreed with the proposal in the Kinder Report to establish midwife-led units in Drogheda and Cavan which at present have the services / equipment and consultant expertise on site. The Council indicated that following the successful implementation of the midwife-led units in Drogheda and Cavan and the establishment of exact protocols and guidelines together with ongoing research, a pilot service in Dundalk and Monaghan, (as outlined in the Kinder Report), may be an option for consideration. However, the Council was not in favour of stand alone midwife-led maternity units at this stage.

8 Having reviewed the international literature and following the consideration of advice from all of the professional bodies consulted, the committee is of the opinion that there is no evidence to support the establishment of midwife-led maternity units in Dundalk or Monaghan hospitals, as outlined in the Kinder Report and the more recent Facilitation Report.

9 The committee recommends the establishment of midwife-led units in Our Lady of Lourdes Hospital, Drogheda initially, followed by Cavan (if implemented successfully in Drogheda), where these units would have the availability of consultant obstetric, paediatric and anaesthetic staff on site.

10 The services provided at these midwife-led units will include antenatal, intrapartum and postnatal care to women who fulfil a set of criteria used to define low intrapartum risk.

OBSTETRIC CARE:

11(i) The committee advises that all babies should be delivered in either Our Lady of Lourdes Hospital, Drogheda or Cavan General Hospital, where there is access to consultant provided twenty-four hour obstetric, paediatric and anaesthetic cover and midwifery staff.
11(ii) The committee recommends that all women in labour should proceed directly to either Our Lady of Lourdes Hospital, Drogheda or to Cavan General Hospital, whichever is in the closest proximity, or summon an ambulance if transport in an emergency is required.

11(iii) A woman who is in labour should only proceed to the nearest general hospital, without a maternity unit, in exceptional circumstances, and should be managed in accordance with agreed protocols.

11(iv) In the event of a general hospital without an on-site consultant staffed maternity unit being faced with an emergency delivery situation, likely to occur within minutes of presentation, the committee recommends that appropriate protocols for emergency delivery, resuscitation and stabilisation of the new born infant on site, consistent with the role and resources of the hospital concerned, are co-ordinated by the Regional Director of Emergency Services, in conjunction with all the relevant professionals, and are circulated, understood and explicitly followed by all relevant health professionals.

11(v) Following stabilisation of mother and baby on site, the committee recommends that they be transferred, by fully equipped ambulance, staffed by trained emergency medical transport staff, to the most appropriate consultant staffed maternity unit. The unit to which mother and baby are referred should be determined by the medical personnel at the hospital at which the delivery took place, based on referral guidelines co-ordinated by the Regional Director of Emergency Services.

11(vi) The committee believes that the above procedures are consistent with best practice, in emergency circumstances, in order to facilitate high quality and safe services to pregnant women and infants, in the North Eastern Health Board area.

**NEONATAL SERVICES:**

12 A regional neonatal unit should be developed at Our Lady of Lourdes Hospital, Drogheda to serve the needs of the entire health board area.

13 The neonatal unit in Drogheda should be staffed by two consultant neonatologists, together with four consultant paediatricians and nurses and other health professionals.

**COMMUNICATION:**

14 Owing to the multi-disciplinary involvement of general practitioners, midwives, obstetricians, paediatricians, anaesthetists and allied health professionals in maternity service provision, it is recommended that these groups should collaborate locally on an ongoing basis and draw up guidelines, to ensure that a high quality and safe service to women and children in the region is provided.
Section 1: Introduction

1.1 ESTABLISHMENT OF THE COMMITTEE

1.1.1 Arising out of correspondence received from the Department of Health & Children, the North Eastern Health Board (NEHB) and various other bodies in January and February 2001, regarding maternity services at Monaghan and Dundalk hospitals, together with a request from the North Eastern Health Board for five additional temporary consultant appointments, Comhairle nOspideal at its meeting on 28th February 2001, established a committee to review maternity services in the North Eastern Health Board area, with the following terms of reference:

"To review obstetric (maternity) and related paediatric, anaesthetic and gynaecological services for the population of the NEHB area, with particular reference to consultant staffing, in the context of current best practice, in order to facilitate high quality and safe services to women and children."

1.1.2 The following members were appointed to serve on the committee:-

- Dr. E. McGovern (Chair), Consultant Cardiothoracic Surgeon, St. James's Hospital.
- Ms. C. Carney, Assistant General Secretary, Impact.
- Dr. E. Connally, Deputy Chief Medical Officer, Department of Health & Children.
- Mr. D. Doherty, Director, The Health Boards Executive.
- Dr. J.J. Gilmartin, Consultant Respiratory & General Physician, Merlin Park Regional Hospital, Galway.
- Dr. M. Gray, General Practitioner, Limerick.
- Dr. P. McKenna, Consultant Obstetrician & Gynaecologist, Rotunda Hospital.
- Dr. T. Ryan, Consultant Neonatologist, Cork University Hospital Group.
- Mr. T. Martin, Chief Officer, Comhairle nOspideal.

Ms. A. Cunningham (A/Administrator) was secretary to the committee and she undertook the research and drafting of this report.

1.2 BACKGROUND

1.2.1 The order of immediately preceding events which led to the aforementioned request and the subsequent establishment of the Comhairle nOspideal Committee are summarised as follows:

1.2.2 The Report of the Review Group on Maternity Services in the North Eastern Health Board (Condon Report) was considered by the Board in November 2000. However, it did not accept in full the recommendations as outlined. In light of the specific recommendation that "Consultant led maternity services at Monaghan and Dundalk must cease in the immediate future", and following correspondence to the Board from the Irish Public Bodies Mutual Insurances Ltd., a special meeting of the NEHB was held on 5th February 2001 at which the following motion was passed:

"That in order to avoid the temporary suspension of Maternity Services at Monaghan General and Louth County Hospitals, the Health Board mandates its Chief Executive Officer to seek, as a matter of urgency, approval for the appointment of Temporary Consultant Obstetricians to Cavan / Monaghan and Dundalk and to seek in addition approval for the immediate appointment of onsite paediatric cover at both hospitals."

1.2.3 In this context, the NEHB, in mid February 2001, sought Comhairle nOspideal approval, for a period of six months, to the following five temporary consultant appointments to be based at:

- Louth County Hospital, Dundalk:
  1. consultant obstetrician & gynaecologist
  2. consultant paediatricians
1.2.4 Around this time the Irish Public Bodies Mutual (I.P.B.M) Insurances Ltd wrote to the Board indicating that in respect of Monaghan and Dundalk hospitals, “we are unable to continue to provide Indemnity cover to the Board in respect of the Maternity Services at these two units unless appropriate interim measures are implemented in the immediate future. We would expect these measures to be in place before the end of February 2001”. According to the I.P.B.M. Insurances Ltd., “no acceptable interim measures were implemented and cover ceased from the end of February.” This decision led to the suspension of maternity services at both Monaghan General Hospital and Louth County Hospital, Dundalk by the NEHB.

1.2.5 In view of the important issues requiring detailed consideration, Comhairle na nOspidéal, on 28th February 2001, deferred a decision on the proposal from the North Eastern Health Board, for five additional temporary appointments, pending consideration of the report of the newly established Comhairle committee. At this stage the health board’s intention to establish a further review of issues involved were known to Comhairle and noted.

1.3 METHODOLOGY

1.3.1 The committee held its initial meeting in March 2001. In pursuance of its task the committee gathered as much detailed information as possible concerning maternity services in the NEHB area and decided upon its consultation programme. At the committee’s request, the health board provided a dossier of information in respect of maternity services in the Cavan / Monaghan and Louth / Meath Hospital Group(s). Detailed information, including, inter alia, workload statistics and policy documents, was submitted to the committee in May 2001. Submissions from a number of individuals and other relevant parties were also received. As a result of further requests by the committee, this information was subsequently supplemented by additional data and literature from the NEHB and various other agencies identified by the committee.

1.3.2 Having analysed the information submitted, together with reviewing the relevant literature, the committee embarked upon the consultation process. A meeting was held with management, medical and nursing representatives of the North Eastern Health Board on 14th November 2001, in Kells. The purpose of the visit was to seek the views of the health board on the provision of maternity and related services within the region, generally, and more specifically, to seek their views in relation to the “Report of the Maternity Services Review Group”, (Kinder Report), which had been adopted by the Board that month.

1.3.3 The committee also met with representatives of the following professional bodies on 14th November 2001: (i) The Institute of Obstetricians & Gynaecologists, (ii) The Faculty of Paediatrics, (iii) The National Council for the Professional Development of Nursing & Midwifery and (iv) The Irish College of General Practitioners.* The purpose of the meeting was twofold, firstly, to seek advice from each of the professional bodies on matters relating to maternity services generally and secondly, to determine their views in relation to the proposed provision of maternity services for the North Eastern Health Board, as recommended in the Kinder Report.

1.3.4 The committee wishes to record its sincere appreciation to the many people and agencies who assisted in its task by means of written submissions and / or consultation. The information and advice received have been particularly helpful in reaching the conclusions set out in this report.

1.3.5 Acknowledging more recent related events in the NEHB area, subsequent contact was made with the health board in 2002 and in 2003. Additional documentation was received and considered.

*Note The College of Anaesthetists were also invited to attend and a response had been received which indicated that representatives would attend, however no representation was present.
Section 2: Description of Existing Services

2.1 MATERNITY SERVICE PROVISION

2.1.1 "Maternity services should support the mother, her baby and her family... with a view to their short-term safety but also their long-term well being. They should help the woman enjoy pregnancy and childbirth as positive, life-changing experiences. The care surrounding pregnancy and childbirth takes place in circumstances which distinguish it from almost all other forms of clinical practice. Pregnancy is not a pathological process or a disease. It is a physiological event which occurs in a very high proportion of women during their lifetimes". In the Republic of Ireland almost all of the approximately 54,000 deliveries each year are hospital based, with less than 1% occurring at home. Vast improvements have been made in the safety record of maternity services in the country over the last 50 years. Better public health, medical advances, particularly advancements in obstetrical and neonatal care and the skill and commitment of all those working within the system, have greatly reduced the infant mortality rate.

It is worth noting that Ireland’s perinatal mortality rate fell by almost a fifth in the 1990s. Over the decade 1990 to 1999, the perinatal mortality rate fell to 8.2 per 1,000 births in 1999, a drop of 18% since 1990, according to the Report on Perinatal Statistics for 1999.

2.1.2 Allied with the substantial reduction in infant mortality rate over the previous four decades, {from 30 per 1,000 in the 1960’s compared to 6 per 1,000 in 1996} there has also been a trend towards the rationalisation of hospital maternity services, into a lesser number of larger maternity units. In 1966, there were 132 hospitals providing maternity services in the Republic of Ireland. Only 40% of the total number of births in 1966 took place in units with over 1,000 births per annum. In 1982, there were 73 hospitals with maternity units and 87% of the total number of births took place in units with over 1,000 births per annum. In 1993, there were 39 hospitals with maternity units and 95% of the births occurred in units with over 1,000 births per annum. In 1996 there were 50,655 births in Ireland with over 95% of the births taking place in units with over 1,000 births per annum. In 2000, there were 54,789 births with 96% of the births occurring in units with over 1,000 births per annum. In 2001 there were 57,882 births, 97% of which took place in units with over 1,000 births per annum. It is evident that the number of hospitals with maternity units has decreased significantly over this timeframe, reflecting the changing pattern in maternity service provision.

2.1.3 Maternity services are characterized by the complexity of their provision, particularly at the time of delivery. While the majority of pregnancies end normally without complication, it is generally accepted that no antenatal screening procedure can guarantee an uncomplicated delivery. The committee concurs with the following view, as stated in the Cumberledge Report: "As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are available".

2.1.4 The imperative for excellence in maternity care stems in part from the following four considerations:-
(i) The importance of childbirth in the life of the young woman means that every opportunity should be taken to make this a positive experience. Despite it’s intensely personal nature childbirth is also a matter of wider concern to the extended family and community.
(ii) The necessity to prevent maternal mortality and significant maternal morbidity.
(iii) The necessity to reduce perinatal death.
(iv) The necessity, for both humanitarian and financial reasons, to reduce as far as possible obstetric omissions or acts that contribute to long-term handicap in children, for example, in some cases cerebral palsy.
2.2 DESCRIPTION OF EXISTING MATERNITY SERVICES IN THE NORTH EASTERN HEALTH BOARD AREA.

2.2.1 Up until the end of February 2001 there were four maternity units in the region located at the following sites:- Cavan General Hospital, Monaghan General Hospital, Our Lady of Lourdes Hospital, Drogheda and Louth County Hospital, Dundalk.

Table 2.1: 1999 - The number of live births for the years 1999, 2000, 2001 and 2002 in respect of the four hospitals.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of live Births in 1999</th>
<th>No. of live Births in 2000</th>
<th>No. of live Births in 2001</th>
<th>No. of live Births in 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drogheda</td>
<td>2,054</td>
<td>2,114</td>
<td>2,958</td>
<td>3,280</td>
</tr>
<tr>
<td>Dundalk</td>
<td>497</td>
<td>546</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>Cavan</td>
<td>917</td>
<td>876</td>
<td>1,134</td>
<td>1,300</td>
</tr>
<tr>
<td>Monaghan</td>
<td>344</td>
<td>298</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3,812</td>
<td>3,834</td>
<td>4,188</td>
<td>4,580</td>
</tr>
</tbody>
</table>

Source: North Eastern Health Board


Information supplied by the North Eastern Health Board indicates that in relation to the Cavan / Monaghan Hospital Group there were 21 cases of neonatal death and there was no case of maternal mortality during the period 1991 – 2000. For the Louth / Meath Hospital Group, there was a total of three perinatal deaths and there was no case of maternal death for this period.

The following tables outline the level of maternity services provided during 1999 in the North Eastern Health Board:-

Table 2.2: 1999

<table>
<thead>
<tr>
<th>Maternity</th>
<th>Drogheda</th>
<th>Dundalk</th>
<th>Cavan</th>
<th>Monaghan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Births</td>
<td>2054</td>
<td>497</td>
<td>917</td>
<td>344</td>
</tr>
<tr>
<td>Pre-term delivery rate</td>
<td>5.27%</td>
<td>1.4%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>a % of overall total deliveries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caesarean section rate</td>
<td>24.13%</td>
<td>23%</td>
<td>26.8%</td>
<td>20%</td>
</tr>
<tr>
<td>Induction Rate</td>
<td>20%</td>
<td>29%</td>
<td>30%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: North Eastern Health Board
Table 2.3: 1999

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Droghea</th>
<th>Dundalk</th>
<th>Cavan</th>
<th>Monaghan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient Attendances</td>
<td>2963</td>
<td>1074</td>
<td>2031</td>
<td>1310</td>
</tr>
<tr>
<td>Day Procedures</td>
<td>239</td>
<td>291</td>
<td>342</td>
<td>191</td>
</tr>
<tr>
<td>In-patient Admissions</td>
<td>1232</td>
<td>597</td>
<td>370</td>
<td>337</td>
</tr>
<tr>
<td>Major Procedures</td>
<td>172</td>
<td>141</td>
<td>315</td>
<td>193</td>
</tr>
<tr>
<td>Minor Procedures</td>
<td>455</td>
<td>613</td>
<td>127</td>
<td>292</td>
</tr>
<tr>
<td>Waiting List</td>
<td>3 months</td>
<td>3 months</td>
<td>&lt;3 months</td>
<td>None</td>
</tr>
</tbody>
</table>

Source: North Eastern Health Board

Table 2.4: 1999

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Droghea</th>
<th>Dundalk</th>
<th>Cavan</th>
<th>Monaghan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Neonates Inborn</td>
<td>605</td>
<td>No Neonatal Unit</td>
<td>82</td>
<td>No Neonatal Unit</td>
</tr>
<tr>
<td>Admitted Neonates Outborn</td>
<td>42</td>
<td>No Neonatal Unit</td>
<td>N/A</td>
<td>No Neonatal Unit</td>
</tr>
</tbody>
</table>

Source: North Eastern Health Board

2.2.2 The obstetric & paediatric permanent consultant staffing complements approved by Comhairle na nOspidéal as at February 2001 (commencement of this committee) were as follows:

Table 2.5: Consultant Staffing as at February 2001

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Louth / Meath</th>
<th>Cavan / Monaghan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>4 posts</td>
<td>3 posts</td>
<td>7 posts</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3 posts (2 Paediatricians) (1 Neonatologist)</td>
<td>3 posts (3 paediatricians)</td>
<td>6 posts</td>
</tr>
</tbody>
</table>

Source: Comhairle na nOspidéal
2.2.3 During the lifetime of this committee additional posts of consultant obstetrician & gynaecologist and consultant paediatrician were approved by Comhairle na nOspídaleá, in line with the recommendations of this committee. The current obstetric & paediatric permanent consultant staffing is as follows:-

Table 2.6: Consultant Staffing as at July 2003

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Louth / Meath Hospital Group</th>
<th>Cavan / Monaghan Hospital Group</th>
<th>No. of New Posts Approved Since February 2001</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>6 posts</td>
<td>3 posts</td>
<td>2 new posts</td>
<td>7 posts</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>5 posts (4 Paediatricians)</td>
<td>3 posts (3 paediatricians)</td>
<td>2 new posts</td>
<td>8 posts</td>
</tr>
</tbody>
</table>

Source: Comhairle na nOspídaleá

2.2.4 Following the suspension of maternity services at Dundalk & Monaghan from 1st March 2001, a re-configuration of maternity service provision occurred within the NEHB. Service provision can be summarised as follows:-

Our Lady of Lourdes Hospital, Drogheda has the largest maternity unit in the region, with 3,280 live births in the year 2002. The unit provides a service for most pregnancy complications, including high-risk pregnancies for low birth weight infants. It provides the spectrum of obstetric, gynaecological, and paediatric / neonatal care, including in-patient and out-patient services. The Regional Neonatal Unit is on-site and is staffed by two paediatricians and one neonatologist.

Cavan General Hospital has a maternity unit which had 1,300 live births in the year 2002. The services provided are similar to Drogheda with the exception of women with complicated pregnancies and women expected to deliver before 32 weeks of gestation (with a low fetal weight), who must be transferred to an appropriate level of care, as there is no neonatal unit on site. Services provided at this unit also include antenatal and postnatal care, and out-patient and in-patient services in respect of gynaecology.

Monaghan General Hospital & Louth County Hospital, Dundalk:
Arising from the recommendation in the Condon Report which stated “Consultant led maternity services at Monaghan and Dundalk must cease in the immediate future”, and decisions by the Irish Public Bodies Mutual Insurances Ltd and the North Eastern Health Board, the provision of consultant led obstetric services at Monaghan and Dundalk hospitals ceased from the end of February 2001. The related services currently provided at these hospitals include antenatal and postnatal care and out-patient services in respect of gynaecology. The development of ambulatory paediatric outpatient services is envisaged by the health board to include primary care paediatrics, community paediatrics, emergency clinics and day care paediatrics.

2.3 DEMOGRAPHICS
2.3.1 During the committee’s consultation process, the health board informed the committee that an increase in births had been experienced recently arising from both the growing population in the health board area and the location of refugees / asylum seekers in the region, in particular near Drogheda. In this context, it had been estimated by the health board, that the total number of births would increase to approximately 4,200 for the NEHB
region, in the year 2001/2002, with a projected figure of 3,000 births in O.L.O.L.H., Drogheda and 1,200 in Cavan General Hospital. This estimation has come to fruition. (see table 2.1)

2.3.2 Notwithstanding the above, it was evident from submissions received that a significant proportion of mothers resident in the NEHB area give birth in hospitals outside the region. By extrapolation of data received from the NEHB, the following table outlines the percentage distribution of births from NEHB-resident mothers, by hospital attended for delivery:

Table 2.7: Where NEHB resident mothers give birth

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of Births*</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Lady of Lourdes, Drogheda</td>
<td>2054</td>
<td>42%</td>
</tr>
<tr>
<td>ERHA Hospitals</td>
<td>1015</td>
<td>21%</td>
</tr>
<tr>
<td>Cavan General Hospital</td>
<td>917</td>
<td>19%</td>
</tr>
<tr>
<td>Louth County Hospital, Dundalk</td>
<td>497</td>
<td>10%</td>
</tr>
<tr>
<td>Monaghan General Hospital</td>
<td>344</td>
<td>7%</td>
</tr>
<tr>
<td>Midland Health Board hospitals</td>
<td>70</td>
<td>1%</td>
</tr>
<tr>
<td>Western Health Board</td>
<td>8</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td>North Western Health Board</td>
<td>3</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4908</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

* Based on 1999 figures.

It is noted that close to one quarter of births to mothers residing in the north east take place outside the region, mainly in the Dublin maternity hospitals. The committee took due cognisance of the above matters when formulating its recommendations. (See Sections 4 & 5)
Section 3: Literature Review

3.1 Members undertook an extensive literature review and a bibliography is provided at Appendix A. The main points identified from a review of the literature are set out in this section.

3.2 Both the Condon Report* (November 2000) and the Kinder Report* (September 2001) were important reference documents for the committee and provided various models of maternity and related care for consideration together with a useful profile of existing maternity and paediatric services in the North Eastern Health Board area.

3.3 The following recommendations are outlined in the Condon Report*:

- "All women in the North Eastern Health Board must have access to maternity services of the highest possible quality."
- "Level 2 maternity units must be staffed by a minimum of three consultant obstetricians, three consultant paediatricians and three anaesthetists."
- "Consultant led maternity services at Monaghan and Dundalk must cease in the immediate future. The provision of consultant led maternity services at Monaghan and Dundalk is no longer supported by the recent recommendations from the Institute of Obstetricians and Gynaecologists. The number of births is insufficient to provide consultants with sufficient experience to maintain their own skills or to train non-consultant hospital doctors."
- "An integrated model of maternity care must be provided in a hub-and-spoke fashion by the two existing centres in each hospital group, i.e. Drogheda and Cavan."
- "The provision of Consultant provided out-patient services (out-reach services) at Monaghan and Dundalk Hospitals."
- "The consultant obstetrician / gynaecologist establishment for the North Eastern Health Board as a whole must include individuals with special interests in many of the major sub-specialties in obstetrics and gynaecology."

3.4.1 In reviewing the Kinder Report* it was noted that the North Eastern Health Board's vision for the future of maternity services requires far reaching change in organisational arrangements and that a Task Force has been appointed to facilitate the implementation programme and the development of appropriate protocols for maternity service provision. The report recommends a total consultant staffing complement of nine Consultant Obstetricians & Gynaecologists and ten Consultant Paediatricians for the NEHB area. The distribution is outlined as follows,

**Louth / Meath Hospital Group:**
- Six Consultant Obstetricians & Gynaecologists
- Six Consultant Paediatricians with a service configuration of:- two General Paediatricians, two Neonatologists and two Paediatricians with a special interest in community child health.

**Cavan / Monaghan Hospital Group:**
- Three Consultant Obstetricians & Gynaecologists
- Four Consultant Paediatricians, i.e. two general paediatricians and two paediatricians with a special interest in community child health.

3.4.2 There are a number of other recommendations in the Kinder Report which the committee notes. These are outlined below.

- "A Level 3 Obstetric unit* based at Our Lady of Lourdes Hospital, Drogheda, together with the Regional Neonatal Intensive Care Unit. Services provided in the unit will include all pregnancy complications cared for, rapid access to adult intensive care facilities, neonatal intensive care for all viable birthweights, epidural anaesthesia should be available to over
80% of women having caesarean section, obstetric ultrasound to tertiary care standards, perinatal audit and perinatal autopsy to agreed quality standards.”

- “A Level 2 Obstetric Unit* based at Cavan General Hospital together with a Level 2 Special Care Baby Unit.”

- “Development of an ambulatory paediatric outpatient service in Dundalk and Monaghan to include primary care paediatrics, community paediatrics, accident and emergency consultations, day care paediatrics and out-patient clinics.”

- “Provision of shared care in the community between the general practitioner and the maternity services, with the emphasis on patient choice, effective communication, mutual professional respect and promotion of teamwork”.

- The North-Eastern region should be self-sufficient as far as possible in providing maternity and childcare, offering a comprehensive range of services”.

- Midwife-led units in Cavan and Drogheda… which will permit community midwifery development”.

*For explanation of Level 1, level 2 and level 3 obstetric units see Appendix C.

3.4.3 The report also recommends the establishment of a regional centre for maternity services at Drogheda. It states that “an essential component of an integrated, comprehensive mother and child service should be the provision of a focal centre within the region. We believe that Our Lady of Lourdes Hospital, Drogheda can best develop this role, given its Category 3 status and the existing training arrangement with education centres in Dublin. Such links will improve the quality of services and will help with the recruitment of staff”.

3.5 The committee received submissions from the Institute of Obstetricians & Gynaecologists* and from the Faculty of Paediatrics* of the Royal College of Physicians. These professional bodies advised the Comhairle committee on the provision of safe and efficient maternity services nationally, together with specific recommendations in respect of the North Eastern Health Board area.

3.5.1 The views of the Institute of Obstetricians and Gynaecologists on the staffing of maternity units, throughout the Republic of Ireland, generally, are as follows:-

- “All obstetric and gynaecology units require three consultants to be recognised for specialist training
- The Institute considers that a viable unit to enable consultants to maintain their expertise and trainees to develop their skills requires in the region of 1,000 births per annum.
- The minimum staffing requirements to provide a 24 hour, 365 days per year (cover) for a maternity unit should be at least 3 consultant obstetricians with appropriate paediatric and anaesthetic services.”

3.5.2 The Faculty of Paediatrics, of the Royal College of Physicians of Ireland, is the professional body representing the specialty of paediatrics in Ireland. The Faculty is of the view that, ideally, all babies should be delivered in units with consultant obstetric and paediatric staff readily available. The submission* from the Faculty of Paediatrics outlined the following in respect of maternity services in the NEHB, in the aftermath of the publication of the Condon Report:

- “The Faculty agrees with the recommendation that the consultant-led maternity services at Monaghan and Dundalk cease. The number of births in Monaghan and Dundalk is insufficient to provide Consultant Obstetricians with sufficient experience to maintain their own skills or to train non-consultant hospital doctors.”

- “Consultant Paediatricians should not be appointed in an attempt to keep open non-viable Consultant-Led Maternity Units. All consultant Paediatric appointments should be made as part of an integrated comprehensive Children’s Health Service in the Health Board area.”

- “The Faculty recommends that Drogheda be developed as the only Regional Neonatal Intensive Care unit in the North Eastern Health Board. The possible implication of considering Drogheda and Cavan both as level 2 Obstetric units is that both would provide neonatal intensive care; we do not believe that the number of deliveries in Cavan would justify this”.

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• “In Cavan, short-term intensive care including skilled resuscitation, stabilisation and short term assisted ventilation should be provided”.

• The immediate appointment of a second consultant paediatrician / neonatologist to the Regional Neonatal Intensive Care Unit in Drogheda”

• “The Faculty does not support the development of free-standing isolated Midwife-Led Maternity Services. The members of the Faculty believe that all infants, in a country the size of Ireland, should ideally be delivered in a unit where the full range of skilled emergency care for the newborn infant is immediately available, if required”.

3.6 The Report of the Acute Hospitals Review Group (Hayes Report), (2001), established some broad parameters and guidelines in relation to the provision of and access to maternity services in Northern Ireland. The report endorses the view that inpatient obstetric services should be provided only where there is access to 24 hour paediatric and anaesthetic cover in conjunction with a sufficiently large caseload to justify a full consultant team. The report pointed out that consultant-led maternity units providing a full range of services appropriate to women with high risk pregnancies should have the following services available: obstetrics; anaesthetic services and access to adult intensive care; neonatal resuscitation, stabilisation and access pathways to neonatal intensive care; midwifery, radiology and blood transfusion. With regard to the issue of midwife-led maternity units the report states “We recognise the value of midwife-led units as a means of broadening the options available to women, and we support the provision of such units on sites where they have the support of consultant-led obstetric, paediatric and anaesthetic services”.

3.7 The potential for developing midwife-led care was considered in detail by a multi-disciplinary study group – the Northern Ireland Maternity Unit Study Group - established by the D.H.S.S. The report “Delivering Choice” (1994) points out that “As unforeseen consequences can occur in any birth, the optimum conditions for the safety of the woman and baby can best be achieved in maternity units which offer full support facilities and expertise”. Its guidelines are based on the belief that the safety of mother and child is paramount. It states “Every woman should have access to consultant care in units where emergency services are available and which offer appropriate obstetric, paediatric and anaesthetic services”. While promoting the above, the report also advocates the element of choice together with quality of care in maternity service provision. It states that there is a need for women to be offered genuine choice in the range of care available, balanced by professional advice on what is appropriate to each woman’s circumstances. It acknowledges the important role of the midwife, who is skilled in providing care and advice to women during pregnancy, labour and the postnatal period. While the report supported the development of midwife-led units on acute hospital sites to extend a range of care options available to women, it did not favour stand-alone midwife and /or GP-led maternity units on sites without consultant staffed maternity units. It recommended that where a woman decides to refer herself to a midwife, the GP and obstetrician should be involved in accordance with agreed guidelines and protocols.

3.8 There is evidence in the international medical literature that midwife-led units, adjacent to, or on the site of conventional consultant-led maternity units, function effectively and are popular. Randomised controlled trials of these units have been carried out at centres such as Aberdeen and Glasgow. Many of these units aim to provide a “homely” environment where women can retain choice and control in the management of their childbirth experience. A systematic review of randomized and quasi-randomised trials comparing home-like birth settings, adjacent to or near conventional labour wards, has been carried out by the Cochrane collaboration and last updated in July 2001. Six trials involving 9,000 women were included in the review.

The review found that substantial numbers of women allocated to home-like settings were transferred to standard care either before or during labour. Those who received care in the home-like setting, adjacent to conventional labour wards, were less likely to have pain relief, had fewer operative deliveries and were less likely to report dissatisfaction with care. Regarding safety, there was a trend towards higher perinatal mortality rates observed with
care in the home-like setting, but this was not statistically significant. The trend towards increased perinatal mortality was observed in trials where women attending home-like settings received antenatal care which differed from the conventional care. One of the reviewers' conclusions was that “Just as an over-enthusiastic focus on risk and intervention can lead to unnecessary interventions and avoidable complications for healthy childbearing women and their foetuses, an over-emphasis on normality may lead to delayed recognition or action regarding complications. Caregivers and their clients should be alert to the need for detection and prompt action in the event of unforeseen complications”.

3.8.1 Unequivocal evidence regarding the safety and efficacy of free-standing midwife-led units is not available. The Cochrane review in 2001 (referred to in 3.8) could find no randomized trial which compared care in a free-standing centre with conventional hospital-based care. There is a wide body of conflicting evidence in the international literature, based on non-randomised study designs, concerning the safety of free-standing units and other forms of care such as home births. Interpretation of this research evidence is extremely difficult because the results of non-randomised studies may be subject to bias and the numbers studied are frequently too low to detect statistically significant results. For example an evaluation of midwife-led care for low risk pregnancies at a stand alone unit in Bournemouth, nine miles from the nearest consultant obstetrician in Poole, found that there was no difference in proportions of low birth weight, babies transferred to special care or congenital abnormalities, between women booking for delivery in the midwife-led unit compared with a similar population of women in the consultant-led unit. However, a high proportion of women (27.1%) who had booked into the midwife-led unit were transferred to the consultant-led unit for care before labour and a further 9.2% transferred during labour. It was not possible to collect reliable information on stillbirths and infant deaths for this evaluation. The authors noted that even if the information was available, the numbers studied were so low as to preclude any statistically significant analysis.

3.8.2 An analysis of perinatal mortality rates in isolated general practitioner maternity units was carried out at the Bath Unit for Research into Paediatrics over a three year period, 1984 – 1987. Over 14,000 deliveries were included in the analysis. Over one third of deliveries took place in seven isolated GP maternity units, 8% in the integrated GP / Consultant unit and the remainder in the consultant staffed unit. The results showed a perinatal morality rate of 4.8 /1,000 births in the isolated GP units compared to 2.8 /1,000 in the consultant led unit and zero in the integrated unit. The findings also showed that perinatal death attributable to asphyxia was more common in the isolated units (1.5 per 1000) than the consultant units (0.6 per 1000). Deficiencies in both antenatal and intrapartum care were deemed responsible for the higher perinatal mortality rate. The integrated unit, which shared midwifery staff with the consultant unit worked well. In relation to the isolated GP units the study concluded that “care given in isolated units needs to be improved, perhaps by better training of general practitioners and consultant supervision of antenatal care”.

3.9 The following recent reports were considered by the committee and noted:


(ii) A review of a clinical adverse event in December 2002, North Eastern Health Board Corporate Risk Manager & Risk Advisor, December 2002

(iii) Report on the Case of Denise Livingstone and Bronagh Livingstone, NEHB, Medical Advisor to the North Eastern Health Board Management, December 2002

(iv) Independent Facilitation Report, St. Paul Consultancy at the request of the North Eastern Health Board, February 2003.
Section 4: The Major Issues Considered by the Committee

4.1 STATUTORY FUNCTIONS OF COMHAIRLE NA NOSPÍDÉAL

4.1.1 Comhairle na nOspidéal is a statutory body established under the Health Act, 1970. Its statutory functions are defined as follows:

(i) to regulate the number and type of appointments of consultant medical staffs and such other officers or staffs as may be prescribed, in hospitals engaged in the provision of services under this Act;

(ii) to specify qualifications for appointments referred to in paragraph (i) subject to any general requirements determined by the Minister;

(iii) to advise the Minister or any body established under this Act (e.g. health boards) on matters relating to the organisation and operation of hospital services;

(iv) to prepare and publish reports relating to hospital services;

(v) to perform such other cognate functions in relation to hospital services as may be prescribed.

4.1.2 In view of its statutory functions alluded to above, Comhairle na nOspidéal focuses mainly on consultant staffing and related matters. However, given that the Condon and Kinder reports deal with midwife-led units as an alternative to consultant staffed units, the committee has made specific observations and recommendations on the full spectrum of maternity and related services, including mid-wifed led units. Comhairle na nOspidéal aims to perform its statutory functions to the best of its ability, in the public interest, thereby facilitating high quality and safe hospital services.

4.1.3 In order to facilitate high quality and safe maternity services to women and children in the North Eastern Health Board area, the committee recognises that this must be consistent with national and international best practice while simultaneously being guided by the principles of equity and quality together with a woman / family centered approach to care. The exacting standards in maternity and paediatric care now sought by both the medical profession and the public are significantly higher than even a few years previously, thereby necessitating very careful consideration of all related matters.

4.2 CONSULTANT-LED MATERNITY UNITS

The professional advice received by the committee, was that in-patient obstetric services should be provided only where there is access to consultant provided 24 hour obstetric, paediatric and anaesthetic cover and midwife staff. The committee endorses this view. It believes that high quality and safe maternity services, with optimal outcomes for both mother and baby can best be achieved by this model of care. Close contact at an early stage between obstetricians, anaesthetists and paediatricians is of optimal benefit to the outcome for women and babies alike, in the context of an imminent complicated delivery. The provision of a consultant led multi-disciplinary team maternity service in both Cavan and Drogheda hospitals, developed in line with agreed protocols and guidelines based on best medical practice, is the preferred option of the committee.

4.3 THE ROLE OF THE MIDWIFE

The World Health Organization / International Confederation of Midwives / International Federation of Gynaecology & Obstetrics (1992), has defined a midwife as:

"A person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualification to be registered and / or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her (his) own responsibility and to care for the newborn and the infant. This care
includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She (he) has an important task in health counselling and education, not only for the women but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She (he) may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

This definition of the midwife and midwifery practice highlights a complex and specialist role.

4.4 THE ROLE OF THE GENERAL PRACTITIONER IN DELIVERING OBSTETRIC CARE

The general practitioner undertakes antenatal care and postnatal care. Obstetric care was normally given by the general practitioner in combination with the consultant obstetrician or midwife. As insurance / indemnity for general practitioners to engage in the routine delivery of babies is not now available in Ireland, this practice has ceased. Medical indemnity insurance covers unforeseen emergency deliveries on a "Good Samaritan" basis only.

Most general practitioners have a contract with the health board to provide care in pregnancy through the "Mother and Infant Scheme" under sections 62 and 63 of the Health Act, 1970. The scheme normally involves a minimum of six antenatal visits which alternate with visits to the consultant obstetrician or midwife, followed by two postnatal visits for the new born, and one postnatal visit for the mother.

4.5 THE ROLE OF THE CONSULTANT OBSTETRICIAN & GYNAECOLOGIST

It is widely acknowledged that consultant obstetricians & gynaecologists are the experts in the care of pregnant women particularly those with complicated pregnancies. The committee also acknowledges that the vast majority of women in Ireland, even those with uncomplicated pregnancies currently choose to deliver in hospitals with consultant obstetric staffing. The role of the Consultant Obstetrician incorporates the following:

- the lead professional for women with complicated pregnancies
- an advisor on actual and suspected abnormalities
- the person responsible for the care of women who have obstetric emergencies
- a provider of technical skills beyond the expertise of midwives / GPs
- fetal medicine
- teaching junior medical staff
- increasing involvement as an administrator / manager
- research

4.6 THE IMPORTANCE OF NEONATAL / PAEDIATRIC AND ANAESTHETIC COVER.

4.6.1 The support of a consultant led paediatric team at the time of delivery is becoming increasingly important. During the consultative phase of its work, the committee was advised of the importance of appropriate resuscitation skills being immediately available at the time of every delivery. Avoidable perinatal / neonatal mortality and morbidity can be achieved in units with on-site paediatric / neonatal cover where there is sufficient throughput of work to enable the professionals to maintain their skills. Combined with the technical skill of resuscitation, there is also a requirement for availability of appropriately trained paediatric staff, to make a correct diagnosis of a possibly serious underlying cause of the failure of the infant to breathe and to instigate the correct treatment. In this context, the committee believes that every newborn has the right to resuscitation performed at a high level of competence with the appropriate facilities on-site. It suggests that all health care professionals present at delivery, should be trained to perform newborn resuscitation together, in a co-ordinated, team approach.

4.6.2 The contribution made by obstetric anaesthetists has substantially changed childbirth for many women over time. Early discussions with an anaesthetist are also beneficial for women with medical problems or obstetric complications, which might limit the choice of methods.
of pain relief or types of anaesthesia appropriate for operative delivery. Anaesthetists have a crucial role to play in the care of some women who become acutely ill in pregnancy, labour and following child-birth. It is the committee's view that in order to minimize mortality and ill-health it is essential that anaesthetists are involved as early as possible when these complications occur or are anticipated.

4.7 VIABILITY OF A MATERNITY UNIT

4.7.1 The question of a viable maternity unit is not just an academic one. Following our consultation process, the committee accepts the broad principles identified by the Institute of Obstetricians & Gynaecologists and the Faculty of Paediatrics, as set out in the previous section. It should be noted that the annual number of births in the Dundalk and Monaghan hospitals, prior to the closure of the units at the end of February 2001, was insufficient for them to operate as viable independent maternity units. The combined births (in the year 2001) of 1,150 for the Cavan / Monaghan Hospital Group and 3,038 for the Louth / Meath Hospital Group provides for two viable units, based at Cavan in respect of the former and Drogheda for the latter, to facilitate a safe and sustainable maternity service to all residents of the NEHB area. The committee observed that the number of births in 1999 and 2000 in Cavan Hospital alone (c.900), (without the input of births from Monaghan Hospital (c.300)), was below the minimum advocated by the Institute of Obstetricians and Gynaecologists to sustain a viable maternity unit. This perspective was put to the committee by some medical representatives of the health board during the consultation process and in submissions to the committee.

4.8 MIDWIFE-LED MATERNITY UNITS

4.8.1 The committee considered the concept of stand-alone midwife-led maternity units vis-à-vis midwife-led maternity units in an acute hospital with the full range of appropriate support services and the aforementioned consultant staffed maternity unit on-site. The committee accepts the broad principles as set out in the literature reviewed (see sections 3.6 - 3.8.3). While noting that the vast majority of deliveries are uncomplicated, the committee took due cognisance of the fact that acute, unforeseen emergencies can occur to the mother or baby at any time during labour or after delivery. Advice received from professional bodies on the matter, indicated serious concern regarding the establishment of stand-alone midwife-led maternity units. The general view of the professional bodies consulted was that the proposal to establish midwife-led units at Dundalk and Monaghan hospitals was not a suitable model for consideration, due to the absence of appropriate on-site consultant staffing to deal with any complex cases which may arise.

4.8.2 The National Council for the Professional Development of Nursing & Midwifery has advised the committee that the concept of midwife-led maternity units in Ireland is at a very early stage and needs to be further developed and researched to ensure that the correct protocols and guidelines are put in place. The National Council agreed with the proposal in the Kinder Report to establish midwife-led units in Drogheda and Cavan which at present have the services / equipment and consultant expertise on site. The Council indicated that following the successful implementation of the above midwife-led units (i.e. in Drogheda & Cavan) and the establishment of exact protocols and guidelines together with ongoing research, a pilot service in Dundalk and Monaghan (as outlined in the Kinder Report) may be an option for consideration. However, the Council was not in favour of stand-alone midwife-led maternity units at this stage.

4.8.3 The Irish College of General Practitioners indicated their support, in principle, for the recommendations set out in the Kinder Report subject to a satisfactory outcome of discussions relating to the continuing role of general practitioners in the provision of combined maternity care for their patients.

4.8.4 In light of the foregoing paragraphs and following the consideration of advice from all of the professional bodies consulted, together with the literature reviewed, the committee supports the concept of midwife-led maternity units only in hospitals where consultant obstetric, paediatric and anaesthetic cover is available on-site, i.e. Our Lady of Lourdes
Hospital, Drogheda and Cavan General Hospital. The committee does not support the establishment of midwife-led maternity units in Dundalk, Monaghan or Navan hospitals, as outlined in the Kinder Report and the more recent Facilitation Report in respect of Monaghan hospital.

4.9 SUB-SPECIALISATION

Within obstetrics and gynaecology there are four sub-specialities that are internationally recognized: (i) perinatology or maternal-fetal medicine, (ii) reproductive medicine, (iii) gynaecological oncology and (iv) uro-gynaecology. Advice given to the committee in respect of the NEHB area, was that at least one of the proposed six posts of Consultant Obstetrician & Gynaecologist, based at Drogheda, should have a designated sub-speciality, in view of the increasing birth rate and the complex cases which a critical mass of up to 4,000 births may provide. Following consultation and deliberation the committee suggests that a special interest in maternal-fetal medicine would be the immediate requirement, (for at least one of the proposed six posts). In addition, the committee recommends that appointments with special interests in the other areas be considered in line with developments in similar size units elsewhere in Ireland.

4.10 REGIONAL NEONATAL CENTRE

4.10.1 According to a submission from the Faculty of Paediatrics, "The aims of a Regional Centre are to ensure that all pregnant women and neonates have adapted health care for their needs; to utilize specially trained personnel for high risk perinatal care and to improve health outcomes while achieving reasonable cost effectiveness." In regional units (which have less than 5,500 annual deliveries) the Faculty recommends that these units should have at least one Consultant Neonatologist who has designated responsibility for the direction and management of the unit including policies, procedures, regional training, audit and liaison with designated smaller units. In their submission, the Faculty recommended 22 neonatal sessions for the North East region.

4.10.2 There is an increasing body of research based evidence that supports the practice of Neonatal Intensive Care. The committee noted from the Report of the Committee on Neonatal Care Services in Dublin, 1988 that Comhairle na nOspidéal recommends one consultant neonatologist per 2,000 deliveries. The British Paediatric Association (in a submission to the above committee), indicated that neonatal intensive care should be associated with maternity units in general hospitals catering for 1,500 – 3,000 births per annum.

4.10.3 The British Association of Perinatal Medicine (BAPM), in a document entitled "Standards for hospitals providing neonatal intensive care" (1996), indicated that an average of between 0.4 to 1.5 cots (high dependency intensive care beds), should be provided per 1,000 births. The necessary staffing / facilities required for neonatal intensive care units were outlined in the document as follows:-

"There should be at least one Consultant Paediatrician with specialist training in neonatal medicine on the staff of the hospital. Each unit should have one consultant who is designated as responsible for the direction and management of the unit. Most of this individual's clinical sessions should be committed to neonatal care. There should be 24 hour cover by consultants who are trained and have recent experience in the supervision of the care of newborn babies. All units undertaking Neonatal Care should be able to demonstrate adequate numbers of appropriately trained and qualified nurses together with a senior nurse with neonatal experience and managerial responsibility." Adequate additional professional support staff is also required.

4.10.4 With regard to equipment required, the BAPM advocate that "Each Neonatal Intensive Care Cot should have available the following:-

(a) Incubator or unit with radiant heating, (b) Ventilator with humidifier (c) syringe / infusion pumps (d) facilities for monitoring respiration, heart rate, intra-vascular blood pressure, oxygen saturation, ambient oxygen.
There must be access to equipment for:-
(a) resuscitation, (b) blood gas analysis, (c) phototherapy, (d) non-invasive blood-pressure measurement transillumination by cold light (f) portable x-rays (g) ultrasound scanning. It is recommended that the existing neonatal care unit at Our Lady of Lourdes Hospital, Drogheda will be further developed in line with the above standards, to provide for the North East region.

4.11 ACCESSIBILITY
An integrated model of maternity care provided in a hub-and-spoke fashion by the two existing centres, i.e. Our Lady of Lourdes Hospital, Drogheda and Cavan General Hospital will ensure that out-reach, consultant provided, out-patient maternity, gynaecology and paediatric services are made available to women and children alike in the Dundalk and Monaghan hospital environs. While the committee acknowledges that the closure of maternity units at Monaghan and Dundalk hospitals by the NEHB has presented some problems with regard to the distances women must now travel, it believes that the subsequent re-establishment of out-patient maternity, gynaecology and paediatric services in Dundalk and Monaghan hospitals, will minimize extra travel impositions on patients. The extra travel, while inconvenient, will be minimized and will be offset by increased health and safety considerations for pregnant women and their babies before, during and immediately after birth.

4.12 CROSS BORDER CO-OPERATION
Having reviewed the data received on the trends vis-à-vis NEHB mothers travelling to Northern Ireland hospitals for maternity services and vice versa, it was evident that only a modest amount of cross border hospital admittance and treatment takes place in both jurisdictions. There may be scope for more formal structured arrangements being developed to support existing good practice on the ground, in the context of the Good Friday Agreement.

4.13 MEDICO-LEGAL CONSIDERATIONS
The committee believes that appropriate, safe and acceptable standards must not only be met, but must be seen to be effective, in respect of staffing, training, equipment and emergency back-up services. During the course of its work, the committee has been made aware of the increasing importance of medico-legal considerations in the future provision of obstetric and maternity care. This has possibly been prompted by a significant rise in public awareness as a result of highly publicised cases and awards. While it is important to place the issue in context nationally, it is inevitable that the concerns raised by some medico-legal issues may have some impact on the provision of maternity care within the North Eastern Health Board, as for all other health boards in the country. Medico-legal considerations further emphasize that a key objective in maternity services provision should be to minimize risk factors, while also highlighting the need for efficient audit and accountability protocols to be put in place.
Section 5: Recommendations

5.1 The policy considerations set out in the previous section, together with the literature review and consultation process have been taken into account in devising the recommendations for the future provision of obstetric (maternity) and related paediatric and gynaecological services for the population of the North Eastern Health Board area, in the context of current best practice, in order to facilitate high quality and safe services to women and children. The committee’s recommendations are set out in the following paragraphs.

5.2 CONSULTANT STAFFING

5.2.1 A total complement of nine Consultant Obstetricians & Gynaecologists and ten Consultant Paediatricians will be required to serve the population of the North Eastern Health Board which is c.345,000 according to the 2002 census. The committee also recommends that adequate consultant anaesthetic cover be provided in the Drogheda and Cavan hospitals. The deployment of the above posts is outlined as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Louth / Meath Hospital Group (Based at Drogheda)</th>
<th>Cavan / Monaghan Hospital Group (Based at Cavan)</th>
<th>Total Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>6 posts (At least 1 with a s.i. in maternal-fetal medicine)</td>
<td>3 posts</td>
<td>9 posts* (9 existing)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>6 posts</td>
<td>4 posts</td>
<td>10 posts* (8 existing)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Louth / Meath Hospital Group (Based at Drogheda)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>6 posts (At least 1 with a s.i. in maternal-fetal medicine)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>6 posts</td>
</tr>
</tbody>
</table>

*In the event of the total population of the NEHB increasing significantly the committee acknowledges that additional consultant staffing may be required to meet increased demand.

Note: 2 additional posts of consultant obstetrician & gynaecologist and 2 additional posts of consultant paediatrician approved in April 2003 by Comhairle na nOspidéal have not yet been filled.

5.3 INTEGRATED MODEL OF MATERNITY SERVICE PROVISION

5.3.1 The committee recommends that an integrated model of maternity care be provided in a hub-and-spoke fashion by the two existing centres, at Drogheda and Cavan hospitals, to ensure that out-reach, consultant provided, out-patient maternity, gynaecology and paediatric services are made available to women and children in the Dundalk and Monaghan hospital catchment areas. There is scope for developing similar out-reach services in Navan Hospital. The committee believes that regular and frequent consultant input should be made to both Dundalk and Monaghan hospitals, by the consultant obstetric & gynaecology and consultant paediatric staff, based at Drogheda in respect of the former and Cavan with regard to the latter. The services provided at Dundalk and Monaghan hospitals may include the following:

5.3.2 Obstetrics:
- Antenatal Clinics
- Postnatal Clinics
- Obstetric Ultrasound
- Parentcraft classes
- Blood Pressure Monitoring
- Diabetes monitoring
- Fetal Assessment

**Gynaecology**
- Colposcopy
- Day case gynaecological surgery

**Paediatrics**
- community paediatrics
- out-patient clinics
- day care paediatrics
- child development
- health promotion
- neo-natal follow-up

The above recommendations are consistent with both the Kinder and Condon Reports.

5.3.3 While the above services would normally be provided by designated consultants, the groups of consultant obstetricians & gynaecologists and consultant paediatricians based at Drogheda and Cavan should each share collective responsibility for supporting each other in ensuring, within reason, continuity of these services to Dundalk and Monaghan hospitals respectively, in the absence of the designated consultant(s), whether on sick leave, holiday leave or other absences.

5.3.4 **OBSTETRIC CARE**

(1) The committee advises that all babies should be delivered in either Our Lady of Lourdes Hospital, Drogheda or Cavan General Hospital, where there is access to consultant provided twenty-four hour obstetric, paediatric and anaesthetic cover and midwifery staff.

(2) The committee recommends that all women in labour should proceed directly to either Our Lady of Lourdes Hospital, Drogheda or to Cavan General Hospital, whichever is in the closest proximity or summon an ambulance if transport in an emergency is required.

(3) A woman who is in labour should only proceed to the nearest general hospital, without a maternity unit, in exceptional circumstances, and should be managed in accordance with agreed protocols.

(4) In the event of a general hospital without an on site consultant staffed maternity unit being faced with an emergency delivery situation, likely to occur within minutes of presentation, the committee recommends that appropriate protocols for emergency delivery, resuscitation and stabilization of the new born infant on site, consistent with the role and resources (staff and equipment) of the hospital concerned, are co-ordinated by the Regional Director of Emergency Services in conjunction with all the relevant professionals, and are circulated, understood and explicitly followed by all relevant health professionals. The committee recommends that protocols for transfer of patients within the health board area are further developed in consultation with the Pre-hospital Emergency Care Council, health board and hospital staff, ambulance staff and other service providers.

(5) Following stabilisation of mother and baby on-site, the committee recommends that they be transferred, by fully equipped ambulance, staffed by trained emergency medical transport staff, to the most appropriate consultant staffed maternity unit. The unit to which mother and baby are referred should be determined by the medical personnel at the hospital at which the delivery took place, based on referral guidelines co-ordinated by the Regional Director of Emergency Services.
(6) The committee believes that the above procedures are consistent with best practice, in emergency circumstances, in order to facilitate high quality and safe services to pregnant women and infants, in the North Eastern Health Board area. These may also have general application nationwide.

5.4 MIDWIFE-LED UNITS

5.4.1 The National Council for the Professional Development of Nursing & Midwifery has advised the committee that the concept of midwife-led maternity units in Ireland is at a very early stage and needs to be further developed and researched to ensure the correct protocols and guidelines are put in place. The National Council agreed with the proposal in the Kinder report to establish midwife-led units in Drogheda and Cavan which are present have the services / equipment and consultant expertise on site. The Council indicated that following the successful implementation of the above midwife-led units (i.e. Drogheda & Cavan) and the establishment of exact protocols and guidelines together with ongoing research, a pilot service in Dundalk and Monaghan (as outlined in the Kinder Report), may be an option for consideration. However, the Council was not in favour of stand alone midwife-led maternity units at this stage.

5.4.2 The committee supports the establishment of midwife-led units (as outlined in the Kinder Report) in Drogheda initially, followed by Cavan if implemented successfully in Drogheda, as these units have the full support of consultant obstetric, paediatric and anaesthetic staff on site. It is envisaged that the services provided at these midwife-led units will include antenatal, intrapartum and postnatal care to women who fulfil a set of criteria used to define low intrapartum risk.

Having reviewed the international literature and following the consideration of advice from all of the professional bodies consulted, the committee is of the opinion that there is insufficient evidence to support the establishment of midwife-led maternity units in Dundalk or Monaghan hospitals, as outlined in the Kinder report and the more recent Facilitation Report.

5.5 REGIONAL NEONATAL CENTRE

The committee recommends that a regional neonatal unit be developed at Our Lady of Lourdes Hospital, Drogheda to serve the needs of the health board area. It is envisaged that the neonatal unit will be staffed by two consultant neonatologists, together with four consultant paediatricians and appropriate support staff. As the number of births increase in OLOLH, Drogheda and with increased complexity of cases, it is recommended that medical and nursing staff working in the unit receive on-going training in neonatology. It is recommended that neonatal intensive care be made available in Drogheda for all viable birthweights and gestational ages. With regard to Obstetrics & Gynaecology, this unit should provide services for all pregnancy related complications, including insulin dependent diabetes, extreme prematurity and multiple pregnancy. As the designated regional centre with approximately 3,300 births per annum, it is recommended that one of the six posts of Consultant Obstetrician / Gynaecologist envisaged for the centre be designated with a special interest in maternal-fetal medicine.

The committee also noted that there is an increasingly expanding role for the National Neonatal Transport Programme (NNTP) which was launched by the Minister for Health & Children in March 2001. To date 415 infants have been transported by the NNTP to regional neonatal centres.23

5.6 COMMUNICATION

While the committee is conscious that maternity services should offer choice to women while simultaneously maintaining optimum safety and quality standards, it believes that choice between options of care must be on the basis of correct information. It recommends that owing to the multi-disciplinary involvement of, inter alia, GP's, midwives, obstetricians, paediatricians, anaesthetists and allied health professionals in maternity service provision, that these groups should collaborate locally on an on-going basis to ensure that the best interests of women and children in the region are met.
5.7 EQUITY & ACCESSIBILITY
The committee considers that the North Eastern Health Board must aim to provide a high quality consultant delivered service, so that women from the health board currently travelling to Dublin and other areas for obstetric and gynaecological care, will increasingly avail of locally provided services and thereby reduce congestion in over-crowded Dublin hospitals. Upon the implementation of the foregoing recommendations which are broadly consistent with those of the Kinder Report and adopted as the health board policy, it is hoped that women resident in the North East, will return to hospitals within the region, to utilise the enhanced maternity and related services available to them.

5.8 CONCLUDING REMARKS
The committee has taken into account the existing network of hospitals in the NEHB area, in conjunction with the ideal configuration of maternity service provision, as set out in the literature, in arriving at its recommendations, which it believes are viable and necessary for the provision of high quality and safe obstetric, and related paediatric, anaesthetic and gynaecology services for women and children in the North Eastern Health Board region. It hopes that the increased number of consultant posts in respect of obstetrics & gynaecology and paediatrics, together with the recommended organisational framework, will facilitate the provision of a significantly improved level of maternity and paediatric services to the women and children resident in the North-East. The committee believes that the implementation of the foregoing specific recommendations will go a long way towards achieving these aims.

23rd July 2003
Appendix A: Bibliography


7. The Faculty of Paediatrics, of the Royal College of Physicians of Ireland, Submission - 3 April 2001.


Appendix B: Submissions Received

The committee received written submissions & information from the following:

- Mr. P. Robinson, CEO, North Eastern Health Board
- Dr. A. McLoughlin, D/ CEO, North Eastern Health Board
- Mr. F. Lennon, Medical Advisor, North Eastern Health Board management
- Mr. M. Fitzpatrick, County Secretary, Monaghan County Council
- Mr. A. Morgan, Louth County Hospital Action Group
- Professor Tom Clarke, (Dean) Faculty of Paediatrics, Royal College of Physicians of Ireland
- Consultant Paediatricians, Louth / Meath Hospital Group and Cavan / Monaghan Hospital Group
- Mr. T. Monks, General Secretary, Irish National Organisation of the Unemployed
- Senator A. Leonard, M.C.C., Smithboro, Co. Monaghan
- Ms. M. B. Murphy, 9 Lakeview, Emlyvale Co. Monaghan
- Mr. D. Ahern, T.D., Louth and Government Minister
- Mr. D. O'Sullivan, Joint Liability Manager, Irish Public Bodies Mutual Insurances Ltd.
- Mr. T. Reid, Department of Health Social Services & Public Safety, Northern Ireland
- Dr. J. Bonnar, Chairman, Institute of Obstetrics and Gynaecology
- Ms. Y. O'Shea, Chief Executive Officer, National Council for the Professional Development of Nursing and Midwifery
- Mr. A. Cunningham, President, College of Anaesthetists, Royal College of Surgeons Ireland
- Consultant Anaesthetists, Louth / Meath Hospital Group
- Dr. T. Ryan, Consultant Neonatologist, Southern Health Board
- Neonatal Subcommittee, Faculty of Paediatrics, RCPI
- Mr. F. Ó Cuinneagain, Chief Executive, Irish College of General Practitioners.
Appendix C: Explanation Notes

According to The Institute of Obstetricians and Gynaecologists, the following outlines what constitutes a Level 3, a Level 2, and a Level 1 Maternity unit.

**Level 3:**
"Level 3 maternity units are the major maternity hospitals with 4,000 – 8,000 deliveries. These units provide a service for all pregnancy complications including high-risk pregnancies for very low birth weight infant, i.e. babies born under 32 weeks gestation. Level 3 units also require one consultant per 300 – 500 deliveries. Consultant sessions for the labour ward and consultant with special training in maternal fetal medicine are required in Level 3 units. The Level 3 units will carry responsibility for Higher Specialist Training in Obstetrics and Gynaecology linked with the gynaecology units of the large general hospitals."

**Level 2:**
"Level 2 maternity units require a minimum of three consultant obstetricians (one consultant to 300 – 500 deliveries) with paediatric and anaesthetic consultant services. Level 2 units will provide general professional and basic specialist training with the doctor in training having supervised responsibility for patient care. The Institute considers that a viable unit to enable consultants to maintain their expertise and trainees to develop their skills, requires in the region of 1,000 births per annum.

**Level 1:**
"Where the number of births in an area is below the level of a viable unit, the Institute proposes that an integrated model of maternity care should be considered. This would require the establishment of a Level 1 Midwifery-led unit which would be for women who fulfill agreed criteria for low intrapartum risk. Agreed criteria for booking Level 1 care and transfer to Level 2 or Level 3 care would operate in the integrated maternity service."