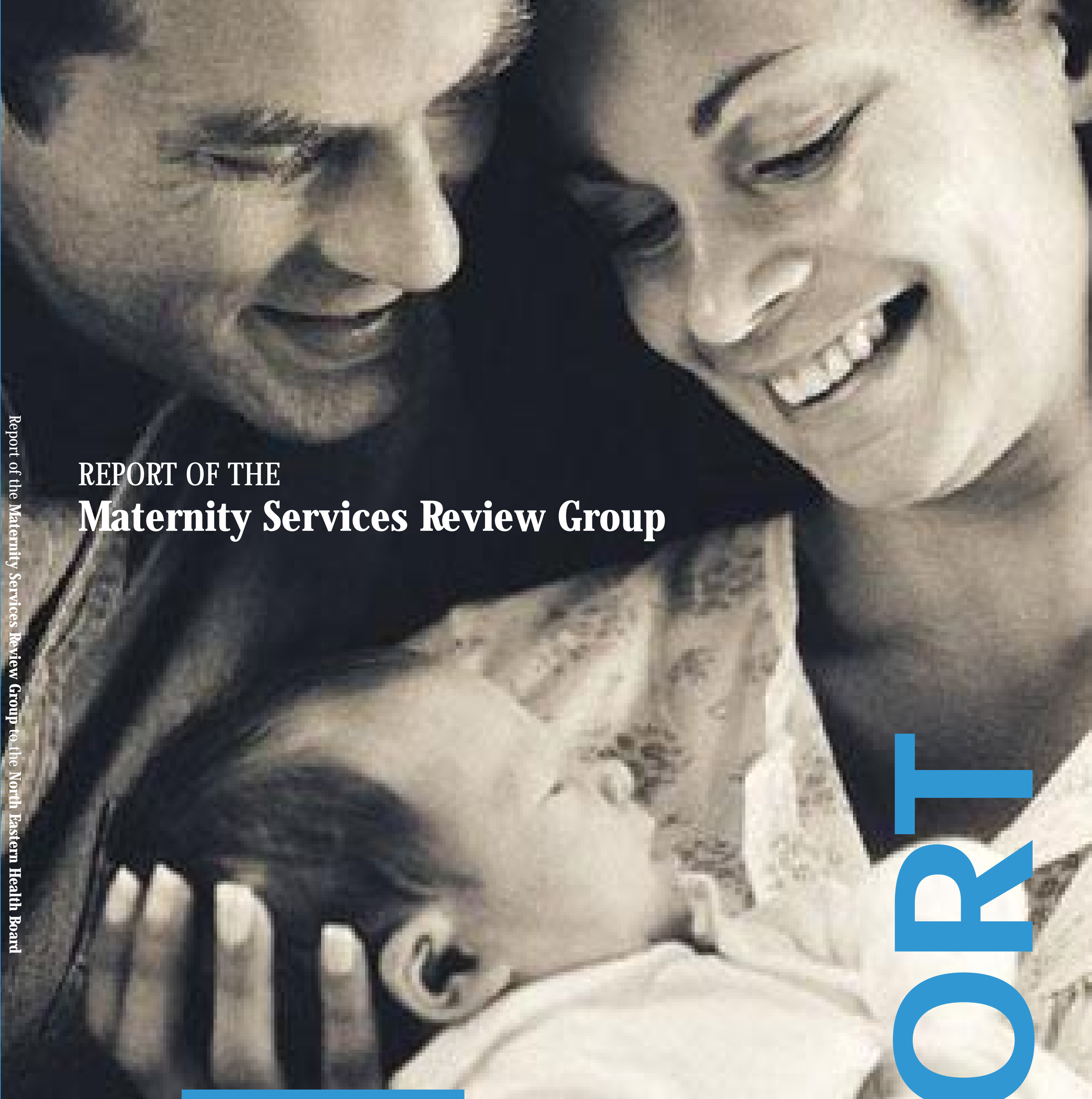

Report of the Maternity Services Review Group to the North Eastern Health Board

REPORT OF THE
Maternity Services Review Group

SEPTEMBER 2001

TO THE
North Eastern Health Board

REPORT

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MATERNITY

1. FOREWORD

"We want women in the region to be able to make an informed choice about where and how their babies should be delivered"

The Review Group was charged with a difficult task within a challenging timescale. Despite the diversity of members' backgrounds, the group worked as a closely-knit team to identify how best to provide quality maternity services to the people of the North Eastern Health Board region. Our aim was to develop a woman-centred, quality service which is safe, accessible and sustainable.

We want women to be able to make an informed choice about where and how their babies should be delivered. In line with national and international policy, we emphasise the key role of the professional midwife in maternity care in the region.

During our consultation process, the group became acutely aware of the concerns of local people about maternity care and the difficulties faced when their local units were closed. We also recognised the need for the region to be self-sufficient in maternity services, particularly in view of the problems of overburdened maternity units in Dublin.

We have, in accordance with our remit, considered population trends and the requirements of spatial planning.

We took advice from professionals, locally and further afield. We learned of trends in maternity care in other parts of Europe and beyond, and we were particularly concerned about the increasing tendency for intervention in normal pregnancy and childbirth.

We are unanimously committed to the recommendations of this report. We are confident that it provides a vision for an innovative, accessible, safe, sustainable and comprehensive maternity service of the highest quality for the North Eastern Health Board region.

Patrick G Kinder
Chairperson

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

2. INTRODUCTION

The North Eastern Health Board decided not to accept in full the recommendations of the Condon Report, a document produced in November 2000 by a Review Group on maternity services in the region.

Following the issue of the Condon Report, the Board was forced to temporarily suspend maternity services at Monaghan General Hospital and Louth County Hospital due to the withdrawal of insurance cover by Irish Public Bodies Mutual Insurances at the end of February 2001 for services at those sites.

Subsequently, the Board agreed the make-up of a further Independent Review with a broader remit at a meeting held on 26 February 2001.

The Maternity Services Review Group under the Chairmanship of Patrick Kinder first met on 19 May 2001, charged with producing recommendations to the Board by 7 September 2001.

Whilst every effort was made to meet that deadline, the group found it necessary to request an extension of one month to finalise the details of its report.

The remit of the group is detailed In Section 3.

3. REMIT OF THE GROUP

The Maternity Services Review Group was established with the following terms of reference:

- to investigate fully all the options in relation to maternity services in the area of the North Eastern Health Board in the light of current practice, knowledge and developments, both here and abroad and with particular attention to the development of maternity services in the region in response to the potential for cross-border co-operation in maternity services delivery and the projected demographics in Counties Louth, Cavan, Meath and Monaghan and cognisant of the requirements of spatial planning, as anticipated in the Government's National Development plan and
- to involve in this process obstetricians, anaesthetists, paediatricians, senior nurses and midwives, general practitioners, other expert opinion and representatives of user groups in the local communities and to accommodate, as far as is possible, consultation with the wider public, our service users and
- to seek appropriate expert advice from outside the region
- to report to the Chief Executive Officer no later than 7 September 2001

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

4. MEMBERSHIP

Mr Patrick Kinder, Chairperson

(Formerly Chief Executive, Eastern Health & Social Services Board, Northern Ireland)

Professor John Bonnar

Chairman, Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland

Councillor Declan Breathnach

North Eastern Health Board Member - County Louth.

Councillor Patrick Conaty

North Eastern Health Board Member-County Cavan

Mrs Marie Devlin

Consumer representatives nominee from the Western Health and Social Services Council, Northern Ireland

Mrs Mary Duffy

Patient Focus nominee

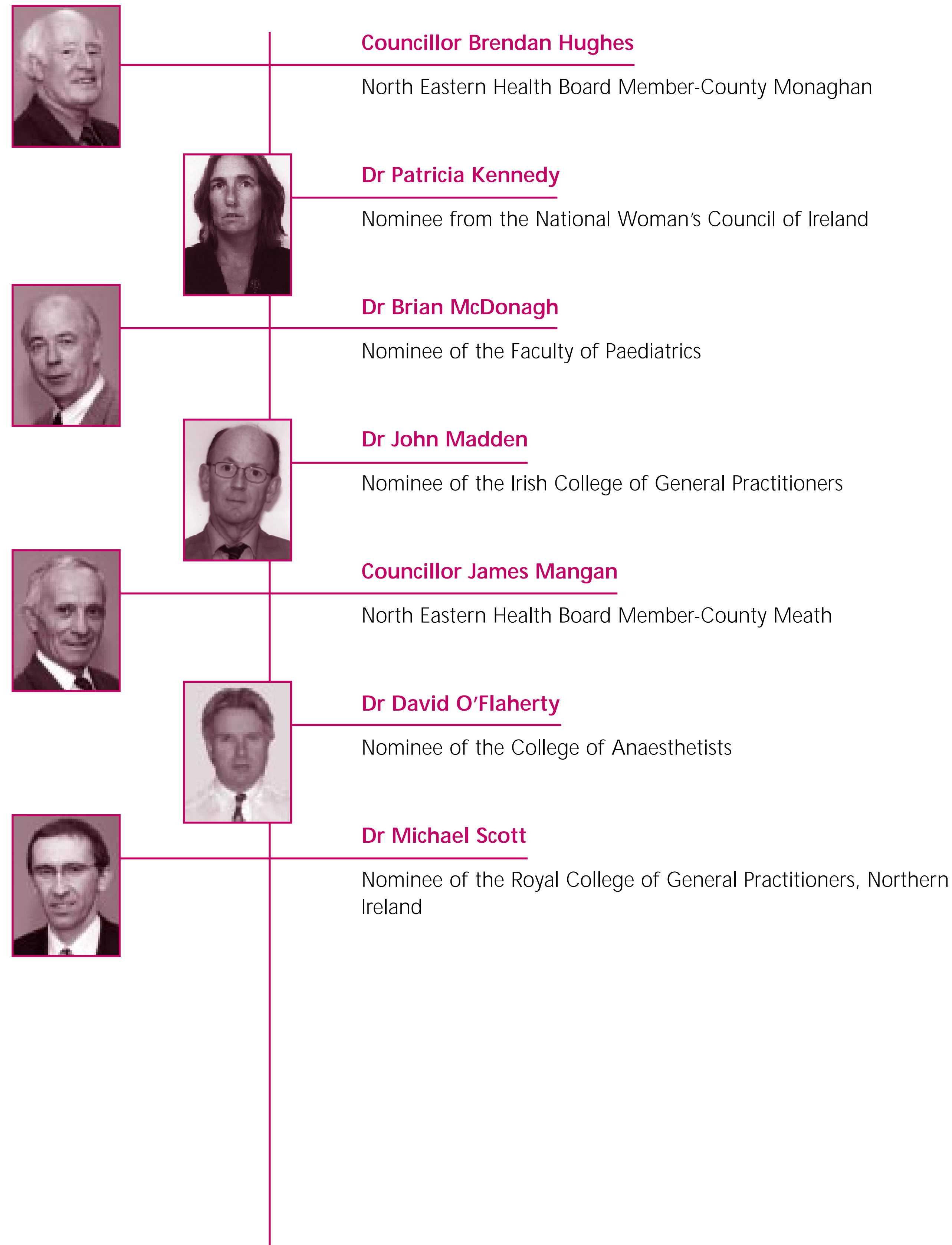
Mrs Ann Farrell

Nominee from the Irish Countrywomen's Association

Ms Barbara Folan

Nominee of the Faculty of Nursing & Midwifery attached to the Royal College of Surgeons in Ireland

4. MEMBERSHIP



Councillor Brendan Hughes
North Eastern Health Board Member-County Monaghan

Dr Patricia Kennedy
Nominee from the National Woman's Council of Ireland

Dr Brian McDonagh
Nominee of the Faculty of Paediatrics

Dr John Madden
Nominee of the Irish College of General Practitioners

Councillor James Mangan
North Eastern Health Board Member-County Meath

Dr David O'Flaherty
Nominee of the College of Anaesthetists

Dr Michael Scott
Nominee of the Royal College of General Practitioners, Northern Ireland

5. METHOD OF WORKING

"We were determined that as many people as possible were made aware of our group and purpose."

5.1 Visits to hospital sites in the region

The Review Group visited Monaghan General Hospital, Louth County Hospital, Cavan General Hospital and Our Lady of Lourdes Hospital in Drogheda. This provided members with the opportunity to meet staff, to view the facilities at each site and to familiarise themselves with the location of each hospital.

Notice of the group's visit was given to each hospital and an invitation was extended to management, medical, nursing and other staff to meet with us to put forward their views on the future of maternity services. Oral submissions were made by staff at each site and the group facilitated later meetings with others who were unable to be present on the date of our visit.

5.2 Consultation with service users

In addition, we were charged with seeking the views of the users of the service - the general public.

We were determined that as many people as possible were made aware of our group and purpose.

An advertisement (Appendix 1) seeking the views of the people of the area on the future of maternity services, emphasising our desire particularly to hear from mothers and potential mothers, was placed in the following local newspapers during the week commencing 28 May: *Observer News; Newry Democrat; Drogheda Independent; Drogheda Leader; Dundalk Democrat; Dundalk Argus; Dundalk Extra; Meath Chronicle; Meath Weekender; Anglo Celt and Northern Standard*. The closing date for receipt of submissions was 30 June.

As we were required to consider the potential for cross-border co-operation, we also wished to reach the public living in the border counties adjacent to the Board's region. The same advertisement was therefore also placed in the following Northern Ireland newspapers: *Newry Reporter; Tyrone Courier; Ulster Gazette; Tyrone Times and Fermanagh Herald.*

An advertisement was broadcast three times per day for one week on local radio stations, LM/FM and Northern Sound.

The group agreed to a request for an extension of the closing date and a further advertisement, providing notice of the revised date was placed in the same newspapers on 13 July (Appendix 2). The extended closing date of 21 July was also publicised on radio stations, LM/FM and Northern Sound for five days, three times daily.

By the end of July, over 170 written submissions had been received (see Section 6 and Appendix 3).

The group also facilitated all requests from local user groups who wished to put forward their views in person.

5.3 Border Counties Maternity Services Forum

Members of the group attended the Border Counties Maternity Services Forum held on 21 June in the Hillgrove Hotel, County Monaghan. The Forum was sponsored by Monaghan County Council and was well attended by health professionals and the public.

Details of the speakers and their presentations are provided in Section 6.

5.4 Presentations by Invited Speakers

We invited two speakers to make presentations.

Dr Murphy-Lawless is a sociologist and research fellow in the Centre for Gender and Women's Studies, Trinity College, Dublin. Mr Porter is Director of Maternity Services of the Wiltshire Health Care NHS Trust, which operates a highly regarded maternity service in a rural area. Local healthcare professionals were invited to hear Mr Porter.

The contents of these presentations are discussed in Section 6.

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

5. METHOD OF WORKING

5.5 Literature review

The group undertook an extensive literature review. Details of the information considered are given in Section 7.

5.6 Review of statistics

We reviewed statistics, particularly those relating to population forecasts, outcome measures of maternity hospitals in the region and projections of future birth rates. Information considered is provided in Appendix 4.

5.7 Developing Proposals

The outcome of our consideration is given in Section 10.

6. WHAT PEOPLE TOLD US

"A total of 170 written submissions were received in response to advertisements in the local press and on local radio stations."

6.1 Written submissions

A total of 170 written submissions were received in response to advertisements in the local press and on local radio stations. A full list of submissions is attached as Appendix 3.

Submissions were categorised under the following headings:

- restoration/upgrading of consultant-led obstetric service at Dundalk
- restoration/upgrading of consultant-led obstetric service at Monaghan
- quality issues
- accessibility issues (distance, time, transport)
- promotion of cross border services
- population projections/catchment growth/statistics
- support for adherence to the recommendations of the Condon Report
- other

If submissions covered topics relevant to more than one heading, they were included in multiple categories.

The **retention or upgrading of a consultant-led obstetric service at Dundalk** attracted 113 written submissions (68.9%). A total of 23 written submissions (14%) promoted the **retention or upgrading of a consultant-led obstetric service at Monaghan**. The majority of the submissions under this category praised the standards of the service previously provided in the respective maternity units.

A number of **quality issues** were raised, the majority of which (52 responses, 31.7%) related to perceived problems at Our Lady of Lourdes Hospital at Drogheda where quality of care, overcrowded wards, early discharge policies and high rates of readmission were the main concerns. A number of submissions highlighted the need for improved communication and better accountability.

"...accessibility issues covered the wide range of comments received about the distance between current maternity units, the poor road system, the lack of public transport and the length of time it takes for women to travel from home to the appropriate maternity unit."

Other **quality issues** raised included:

- the need for a nursery in Lourdes Hospital
- the lack of community nursing facilities in the region
- a perceived lack of knowledge of how to operate labour room equipment in Lourdes Hospital
- the absence of a post-natal service in Monaghan
- inappropriate waiting times for discharge letters from Lourdes Hospital to local General Practitioners
- a shortfall of maternity/paediatric beds in Cavan Hospital

The heading of **accessibility issues** covered the wide range of comments received about the distance between current maternity units, the poor road system, the lack of public transport and the length of time required for women to travel from home to the appropriate maternity unit. A total of 46 submissions (28%) referred to such problems.

Nine submissions (5.5%) promoted maternity services available in Daisy Hill Hospital in Newry and suggested that **cross-border services** should be made available as an option to women living in appropriate parts of the North Eastern Health Board region.

Fifty-three (32.3%) submissions quoted **population projections or catchment growth** as the basis for their argument, the majority of these being in support of restoration of consultant-led services in Dundalk.

Eight responses (4.9%) provided support for the recommendations of the ***Condon Report***.

Six written submissions (3.6%) sought the development of a **midwife-led service** within the region. Three people referred to the need for women of the region to have equitable access to maternity services. Two people wrote in favour of the appointment of additional paediatric consultants for Cavan and Drogheda to facilitate the expansion of paediatric outpatient clinics in Dundalk and Monaghan.

Single written submissions covered the following topics:

- shortfall in the number of home birth midwives
- absence of a maternity unit in County Meath
- the absence of infertility services
- the range of maternity services available at Cavan/Monaghan Hospitals

6.2 Oral Submissions

Fifteen oral submissions were made: six by individual hospital staff; seven by groups of staff; one by Louth County Hospital Action Group and another by Patient Focus, a group representing patients' views.

Transcripts of these submissions were examined and categorised under the same headings as the written submissions.

Oral submissions that covered topics relevant to more than one heading were included under multiple categories.

Four submissions were in support of the **restoration/upgrading of a consultant-led service in Dundalk**.

Six submissions advocated the **restoration of a consultant-led service in Monaghan** and three suggested that a small unit (not necessarily with the staffing levels required for training purposes) would suffice.

One submission proposed that a maternity service in Monaghan should be restored with the provision of additional consultant cover via a rotational system with Cavan General Hospital.

A number of **quality issues** were raised. Four submissions referred to perceived problems at Our Lady of Lourdes Hospital in Drogheda, the majority of which related to quality of care, insufficient staffing levels and early discharge policies. Some felt that this situation could be further compounded by the additional burden of work from Monaghan and Dundalk.

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

6. WHAT PEOPLE TOLD US

Other **quality issues** included:

- the general shortage of midwifery staff in Ireland and the fact that the maternity unit in Cavan General Hospital is operating with a 50% shortfall in midwifery staff
- the perceived 'downgrading' of Monaghan General Hospital
- concern about losing gynaecology services at Monaghan General Hospital
- the general lack of community support for new mothers on discharge from hospital
- overburdening of Cavan maternity unit when Monaghan maternity unit was closed

The heading of **accessibility issues** again covers the wide range of comments made in the written submissions. Eight references were made to such problems, the majority of which related to distances between Monaghan and Cavan and the poor road system.

Five submissions referred to **statistical data** such as:

- per capita expenditure by the North Eastern Health Board compared to that of other Boards in Ireland
- the number of women in the fertile age range residing in County Monaghan
- population projections for County Louth
- higher level of stillbirths and congenital abnormalities in County Louth

One of the oral submissions was in support of the recommendations of the ***Condon Report***.

Under the generic heading of **other issues**, five oral submissions considered the possible establishment of a midwife-led unit in the region - the majority of which suggested that this should be adjacent to an obstetric unit.

The need for equity in the provision of services across all counties was referred to during three submissions.

It was suggested twice that, regardless of the obstetric situation, a paediatric service should be provided at Monaghan General Hospital due to the volume of 0-16 year-olds in the county.

One submission provided details of the services available at Cavan/Monaghan Hospitals and another promoted the services available at Our Lady of Lourdes Hospital in Drogheda.

Our views on issues raised are contained in Section 8.

6.3 Border Counties Maternity Services Forum

The Border Counties Maternity Services Forum took place on 21 June in the Hillgrove Hotel, County Monaghan. Sponsored by Monaghan County Council, it was arranged primarily to support the restoration and development of maternity services at Monaghan General Hospital. Eight speakers dealt with a wide range of topics and provided information about various models of maternity care.

Dr Eamonn Duffy, a local general practitioner, highlighted difficulties experienced since the closure of the maternity unit in Monaghan and called for the appointment of an additional consultant obstetrician to enable the unit to be reopened.

Ms Eithne McCord, Chairperson of the South Tyrone Action Group, summarised events leading to the loss of maternity units in Omagh and Dungannon and the subsequent sequence of events which resulted in the downgrading of these hospitals.

Ms Marie O'Connor, a research sociologist from Dublin, discussed the recommendations of the Condon Report and considered it lacking on a number of counts. She spoke about the consequences of the report and suggested that it does not achieve the aim of providing high quality maternity care to every woman in the region.

Ms Philomena Canning, Director of the European Institute of Midwifery, outlined the benefits of the social model of childbirth and recommended a return to midwifery led care.

Dr John Murphy, consultant paediatrician from the National Maternity Hospital in Dublin summarised the reasons why it was essential for maternity units to have paediatric services on site.

Mr Richard Porter, consultant obstetrician and gynaecologist from Bath, England, described problems across Europe in the recruitment of medical staff and discussed the future of maternity services. He outlined maternity services in his region where there is one obstetric unit working in conjunction with a number of

"We...were impressed by the opportunity provided by the County Council for the people of Monaghan to learn about the options for the provision of maternity care."

community based midwife-led units and discussed the benefits of his model of care.

Professor Patrick Darcy, Visiting Professor of Nursing, University of Ulster, spoke of the inter-relatedness of one hospital in the region with the others. He considered the impact of the loss of maternity units in Monaghan and Dundalk and the effects on the local community.

Dr Liam Grogan, consultant oncologist in the Beaumont Hospital, Dublin, outlined the interdependence between specialties within hospitals and the effects of the loss of one service upon another.

We took cognisance of the issues raised and were impressed by the opportunity provided by the County Council for the people of Monaghan to learn about the options for the provision of maternity care.

6.4 Presentation by Dr Jo Murphy-Lawless

Dr Jo Murphy-Lawless is a sociologist and research fellow in the Centre for Gender and Women's Studies, Trinity College Dublin. She has published widely on the social aspects of women's reproductive health in both the Irish and international contexts.

Dr Murphy-Lawless spoke to us in early July at the request of one of our members. She highlighted the current debate between proponents of the medical model of birth (including active management of labour and the use of Caesarean section for non-emergency births) and what has become known as the social model of birth.

She summarised factors that have made childbirth safer for women in western countries over the last fifty years. These include the marked improvement in women's general health, better nutrition; control over fertility through access to safe and reliable contraception and the availability of antibiotics to control post-birth infections. There have also been major technological improvements in emergency obstetric procedures.

Dr Murphy-Lawless emphasised that as a consequence of these advances, childbirth is no longer a hazardous experience for women.

6. **WHAT PEOPLE TOLD US**

"The aim of care is to achieve a healthy mother and child with the least possible level of intervention. In normal birth, there should be a valid reason to interfere with the natural process."
World Health Organisation (1996)

The medical model of birth was developed in the late 1960s following technological advances which permitted the safe and controlled administration of oxytocic drugs (to accelerate labour). The 'active management of labour' was pioneered in Holles Street in Dublin. It provides guidelines for starting and controlling labour using intervention techniques to ensure that a woman is not in labour for any more than twelve hours.

Since 1975, of all first time mothers who have given birth in Holles Street, 45% have done so with oxytocic intervention. Fifty-per-cent of first time mothers attending Holles Street now have their labours accelerated using oxytocic drugs and 16% of these women have had their labour induced. Active management of labour is far more painful than normal labour because of the drugs involved, we were told. They make the uterus contract much more sharply, requiring more pain relief which brings its own complications.

Care in Normal Birth: A practical guide (published by the World Health Organisation (WHO) in 1996) was referred to at length by Dr Murphy-Lawless. This publication explores the importance of basing birth management practices on evidence- based care. Evidence-based care represents the findings of thousands of studies about practices which get the best results for women and babies alike in non-complicated labour and birth. They are based on reviews of randomised control trials. The WHO sorts common birth practices into three groups - those which are demonstrably useful and should be encouraged; practices which are clearly harmful or ineffective and should be eliminated and those which are frequently used inappropriately.

Other practices for which insufficient evidence exists to support a clear recommendation were categorised separately.

6. **WHAT PEOPLE TOLD US**

"Results of eleven randomised control trials on the social model of birth demonstrate statistically proven better birth outcomes than with conventional obstetric care."

The WHO identify the following practices as being demonstrably useful:

- empathetic support by caregivers during labour and birth
- respecting woman's choice of companions during labour and birth
- offering oral fluids during labour and delivery
- non-invasive non-pharmacological methods of pain relief during labour such as massage and relaxation techniques
- freedom in position and movement throughout labour
- encouragement of non-supine position during labour

All of these practices are part of what has become known as the 'social model of childbirth' in which pregnancy and birth are not seen as illnesses, but as normal physiological events. The social model of birth restores the process to one free of unnecessary interventions. The woman giving birth is at the centre of the process, where she decides about the form of care she wants. This model emphasises the importance of midwives as the primary caretakers of normal birth. Obstetricians play a back-up role if obstetric emergencies arise.

Dr Murphy-Lawless told us about the results of eleven randomised control trials on the social model of birth which demonstrate statistically proven better birth outcomes than with conventional obstetric care. Reported results from these studies conducted in hospital settings over the last decade include:

- shorter, less painful labours
- less likelihood of intrapartum analgesia (pain-killing drugs during labour)
- less likelihood of operative vaginal delivery, and for babies
- better Apgar scores at five minutes

when compared with the medical model of labour and birth.

Whilst Dr Murphy-Lawless recognised that not every woman will be eligible to give birth distant from an obstetric unit, she discussed the common practice of categorising women as low-risk or high-risk to decide on their eligibility. She explained that this categorisation often fails to accurately predict the outcome of the pregnancy.

"...historical staffing arrangements cannot continue because of a number of factors."

Frequently, women categorised as high risk never develop the complications for which they were thought to be at risk while some women from the low-risk group develop unforeseen complications. Under the social model of childbirth, the midwife carefully watches the woman during labour and her experience will identify if it is necessary to transfer her to the care of an obstetrician.

6.5 Presentation by Mr Richard Porter

Mr Richard Porter is a consultant obstetrician and gynaecologist at the Royal United Hospital at Bath, England. He is the Director of Maternity Services of the Wiltshire Health Care NHS Trust.

We invited Mr Porter to make a presentation to us and to clarify some issues following his participation in the Maternity Services Forum in Monaghan. We had a number of local healthcare professionals join us to hear his presentation which took place on 21 July.

Mr Porter suggests that there is a crossroads in maternity care, not just in the North Eastern Health Board, but throughout Europe. In his opinion, there have been major mistakes made in maternity care over the past fifty years and historical staffing arrangements cannot continue because of a number of factors.

There is a critical situation in paediatric manpower which will inevitably lead to withdrawal of recognition for paediatric training in smaller units. Without a full paediatric service, obstetric training will be less wide-ranging and will subsequently lead to a withdrawal of recognition of obstetric training in many small and medium sized units. So recruitment of junior staff becomes difficult or impossible and could ultimately result in the collapse of obstetric services in such units.

There is a similar crisis in obstetrics. The centrally imposed reduction in numbers of middle grade staff in order to prevent a glut of unemployable fully trained obstetricians has resulted in a manpower crisis. This has led to derecognition of junior obstetric staff posts in smaller units so departments become non-compliant with European Working Time Directives.

"There is a marvellous opportunity to provide responsive, woman-centred services and alternative delivery settings will play increasing importance"

There is no possibility of continuing as we were because there is also a midwifery crisis. Trained staff are leaving the profession in droves. Midwifery practice is no longer consistent with expectations, those trained for a physiological model are having to work with the medical model.

Mr Porter believes that the consequences of all these problems will be that many consultant-led obstetric units will have to adapt and "some will close". Maternity services can, in many places, no longer be provided as they have been. He reckons that between 1994 and 2003, one in four of all maternity units will have closed or merged with others. Many more will have to follow suit.

Change can be considered as a threat or an opportunity, Mr Porter emphasises. Those who view it as a threat say everyone has a 'right' to the provision of a 'standard' maternity service wherever they live. Viewing change as an opportunity, however, means that since it will no longer be feasible for all women to deliver both close to home and in a consultant led maternity unit, we have to consider other options. It provides the chance to reconsider the nature of maternity services provision.

Mr Porter stresses that it is essential to decide on the aspirations of a proposed alteration to a service. Closure is only one of many options. Maternity care is not an illness - it is a wellness service. The disease model must be discarded and the switch made to the social model.

Maternity services should serve and not dictate to the population. A reduced role for obstetricians is inevitable in most cities and will ultimately be demanded by women.

It is not a threat. There is a marvellous opportunity to provide responsive, woman-centred services and alternative delivery settings will play increasing importance.

Mr Porter accepts that the provision of maternity services in a rural society such as in the North Eastern Health Board region is challenging. The area around Bath is also rural, with distances between hospitals of up to 27 miles.

"Midwife-led units are an obvious alternative to closure of smaller consultant led maternity units."

There are alternatives to obstetric-led services - home births, midwife-led units, a midwife-led unit with limited obstetric input, a midwife-led unit with limited anaesthetic input, a midwife-led unit with limited paediatric input. The role of the general practitioner must also be considered.

Mr Porter discussed the unit in which he works within Wiltshire NHS Trust (a level 3 maternity unit). It is the tenth largest in the United Kingdom with 5,200 deliveries annually. Of these deliveries, 30% are in midwife-led units which are at least 30 minutes away (some are 60 minutes away) from the hospital maternity unit. The midwife-led units have no professional staff other than midwives.

In the last ten years, 15,000 women have passed through these units. There are, on average, 200 home births per annum and 13% of all deliveries in the town of Bath are at home, despite the fact that the hospital is very close. There is no other unit like it in the United Kingdom.

There are objections to home deliveries. It is impossible to provide facilities for all conceivable emergencies. There are concerns about the cost of adequate professional cover. Objections to midwife led units are much the same, Mr Porter said. There are advantages, however. They are an obvious alternative to closure of smaller consultant led maternity units. They provide a high level of staff pride and patient satisfaction. There is real scope for professional development for midwives.

The perinatal mortality rate has been historically low in Bath, but between 1997 and 2000 it has been the lowest in the region. It also has the lowest epidural and caesarean section rates. There is no single predominant urban centre and 80% of the population live in rural areas.

There is a clear demand for the service the unit is providing and the local general practitioners support it. It engenders mutual professional respect.

There were difficulties in its establishing Mr Porter's unit. Guidelines and protocols had to be redefined but it has been a positive experience. The Trust has won five UNICEF baby friendly awards, it has no midwifery recruitment problems and it is a very happy unit to work in. For every complaint, it receives 40-60 compliments.

"There is nothing second rate about a midwife-led unit. Rather, communities should consider it as a highly positive, modern and woman-centred service."

The problem of transferring women from a midwife-led unit to the obstetric unit during labour has to be considered. If you are going to deliver 30 minutes (or more) away from help, there has to be an understanding that you will occasionally have difficulties. Staff need to be alert to the possibility of problems before they actually happen.

Our speaker concluded that the current situation is not an option. The climate for change should be considered as a genuine opportunity and not a threat. There is **nothing** second rate about a midwife-led unit. Rather, communities should consider it as a highly positive, modern and woman-centred service.

7. LITERATURE REVIEW

"The Institute of Obstetricians and Gynaecologists require obstetric units to have 1,000 births per annum to ensure that consultants maintain their expertise and junior staff can develop their skills."

Members undertook a literature review and a bibliography of information examined is shown in Appendix 5. However, some documents were considered of major importance to us and their contents are summarised in this section.

7.1 Report of the Review Group on Maternity Services in North Eastern Health Board, 2000 (The Condon Report)

The Condon Report (November 2000) was a very important reference document for us. It provided a useful profile of the North Eastern Health Board area and details of maternity services available in the region at the time of its compilation. We refer you to the models of good practice detailed in the Condon Report, rather than describing them again in this document.

The Institute of Obstetricians and Gynaecologists require obstetric units to have 1,000 births per annum to ensure that consultants maintain their expertise and junior staff can develop their skills. The minimum staffing requirements for a round-the-clock service throughout the year should be at least three consultant obstetricians, together with the appropriate anaesthetic and paediatric services for a woman in labour and the care of a newborn.

These requirements are detailed clearly in the Condon Report and we recognise that this is a major factor in considering a practical solution to the situation in the North Eastern Health Board region.

Condon recommended the cessation of consultant-led maternity services at Monaghan and Dundalk and proposed the establishment of a pilot midwifery-led unit in Dundalk.

7.2 A Framework for Maternity Services in Scotland, Scottish Executive, 2001

This report from the Department of Health and Community Care in Scotland sets out a framework for the provision of maternity services across the country.

"Women must be given information in a suitable format to allow them to understand that equal access to services cannot always be guaranteed..."

It is the product of wide consultation with women and professionals and it provides a template for best practice in maternity care. The report challenges health professionals to meet the needs of women and their partners and gives guiding principles for care from pre-conception and very early pregnancy through to childbirth and parenthood.

It states very clearly that it is not a strategy document, or a model service specification, but a philosophical approach that outlines a set of broad principles to inform local maternity services strategies. The framework is based on the following broad themes:

- safety and evidence-based care for mother and baby must remain the foundation of an effective maternity service
- pregnancy and childbirth are normal physiological processes
- maternity services must deliver a woman and family-centred approach to care and support planned in partnership with the woman
- maternity services should be essentially community based and midwife managed, wherever possible, with an emphasis on continuity of care

There are specific issues that impact on service provision in remote and rural areas and this was of particular interest to us. Women must be given information in a suitable format to allow them to understand that equal access to services cannot always be guaranteed because geographical factors can impact on the services available locally. Women must have information to allow them to make informed decisions by balancing risks.

The report goes on to explain the various levels of care available to women when they are planning the location for the birth of their child. These range from Level 1a (a home birth) up to a Level 3 consultant-led Specialist Maternity Unit.

7.3 Delivering Choice - Report of the Northern Ireland Maternity Unit Study Group, 1994

This report was produced for the Department of Health and Social Services in Northern Ireland. The study group was charged with the responsibility of considering the potential for extending the range of options of care available to women during childbirth through the development of maternity units managed by midwives and/or general practitioners. The report considers three models of maternity care; consultant-led, general practitioner-led and midwife-led services.

"...women should have the right to choose the form of maternity care they want"

The report recommends that women should have the right to choose the form of maternity care they want and that they should be provided with full and accurate information throughout pregnancy to help them make the most appropriate choice. It emphasises the need for consumers to be involved in planning and monitoring services.

The development of new models of care will depend largely on changes in attitudes, receptiveness to new ideas and strong leadership. Investment in training and education is necessary. Close co-operation and mutual trust between all professionals involved is essential.

The group supported the development of midwife-led units on acute hospital sites, but rejected the possibility of a stand-alone midwife and/or GP led maternity unit remote from acute hospital services.

7.4 Report of The Commission on Nursing - A blueprint for the future, Government of Ireland, 1998

The report makes recommendations on the regulation of the nursing profession. The Commission highlights the need for recognition of the distinct identity and concerns of the midwife and proposes legislative changes to the 1985 Nurses Act to confirm midwifery as a separate profession from nursing. It proposes restoring the midwives' statutory committee and revising fitness to practice procedures.

The report explains that midwives have special and exclusive skills related to the natural event of childbirth. It recommends a review of the midwifery education programme and proposes a direct entry midwifery course in a maternity hospital.

"...midwives felt that pregnancy and childbirth should be considered normal, which is contrary to the present medical model of childbirth."

7.5 Review of Scope of Practice for Nursing and Midwifery - An Bord Altranais, 2000

This document provides a framework for the scope of nursing and midwifery practice which provides opportunity and guidance for the determination, review and expansion of nursing and midwifery roles in Ireland. It is intended to guide nurses and midwives in independent decision making regarding changes in their scope of practice and facilitate them in developing new skills to meet patient/client needs.

Issues raised by midwives during consultation are highlighted. Midwives were clear that they wished to be viewed as a profession distinct from nurses and welcomed the recommendations of the Report of the Commission on Nursing (7.4). In general, midwives felt that pregnancy and childbirth should be considered normal, which is contrary to the present medical model of childbirth. Currently many policies are obstetric and not midwifery led. They felt that their role is only to facilitate, or is perceived as being only to facilitate, the obstetrician.

The report provides the definition of a midwife according to the World Health Organisation/International Confederation of Midwives/International Federation of Gynaecology and Obstetrics (1992):

"A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to 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 new-born 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 childcare. She (he) may practice in hospitals, clinics, health units, domiciliary conditions or in any other service."
Midwives want to practice as defined by this definition.

"The need for round-the-clock anaesthetic and paediatric cover, coupled with the importance of maintaining skills and the effective use of scarce resources, suggests that it is not possible to sustain an inpatient (obstetric) unit for fewer than 2,000 deliveries a year."

7.6 Acute Hospitals Review Group Report (The Hayes Report), June 2001

This report makes recommendations about the profile of acute hospital services in Northern Ireland. It considers maternity services as part of its remit and recognises the importance of affording women as much choice as possible in the place of delivery. It emphasises that childbirth is a natural event and should be a joyful and fulfilling experience for mother and partner.

The report refers to debate about the optimal place of delivery following a normal pregnancy. Fully equipped and staffed hospitals are generally thought to be the safest place for all deliveries because no antenatal screening procedure can guarantee an uncomplicated delivery. On the other hand, there are concerns about the concentration of services in a smaller number of units possibly endangering the health of women and babies by reducing accessibility. Centralisation may provide a service that is less 'woman-friendly'.

The report recognises the value of midwife-led units but it supports their provision only on sites where the support of consultant-led obstetric, paediatric and anaesthetic services are available. Additionally, it endorses the view that obstetric services should only be provided where there is access to paediatric and anaesthetic cover on a 24-hour basis. "The need for round-the-clock anaesthetic and paediatric cover, coupled with the importance of maintaining skills and the effective use of scarce resources, suggests that it is not possible to sustain an inpatient (obstetric) unit for fewer than 2,000 deliveries a year". "The entire population of Northern Ireland should normally expect to be within one hour's travel time of a consultant-led maternity unit."

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

8. THE MAJOR ISSUES CONSIDERED BY THE GROUP

"The restoration of consultant led services in Monaghan and Dundalk was the major recommendation made to us in response to our advertisement."

8.1 Consultant-led service

The restoration of consultant led services in Monaghan and Dundalk was the major recommendation made to us in response to our advertisement (82.9%). We therefore examined the proposition very carefully.

The essential reasons put forward in the Condon Report for withdrawal of consultant-led services in Monaghan and Dundalk were the recommendations of the Institute of Obstetrics which require approximately 1,000 births per annum with minimum staffing levels of three consultant obstetricians to provide the service, maintain consultant expertise and meet training needs.

Similar recommendations arose in paediatrics and in anaesthetics.

It was nevertheless held by many people that however strong these reasons are, they represent only the medical view and do not take account of the consequences for mothers and mothers-to-be.

We therefore looked for comparisons with other countries where quality maternity services are provided and we were informed that medical staffing levels take account of similar considerations to those mentioned in the Condon Report.

What was significantly different in countries like the United Kingdom, Holland, New Zealand and Australia, was the type of maternity services offered to take account of accessibility and at the same time offer an informed choice to the mothers-to-be. Maternity services were not just provided in a consultant-led acute obstetric environment but also embraced midwife-led services within an acute obstetric hospital; in an acute hospital environment and in a community setting.

The information available to us, particularly in respect of the United Kingdom, showed that with proper protocols in place, these services met the needs of mothers, giving them greater informed choice and resolving safety problems of accessibility and travel.

"There is, therefore, a clear need to diversify the ways in which maternity services are provided... to avoid over-centralisation of services."

Comparisons elsewhere in respect of the number of births required for consultant-led units show that the trend is towards 2,000 births annually (Acute Hospitals Review Group, 2001) for the same reasons given in the Condon Report. This trend will inevitably lead to a reduction in the number of consultant-led units. There is, therefore, a clear need to diversify the ways in which maternity services are provided in order to overcome the problems which have been brought to our attention and to avoid over-centralisation of services.

We have therefore taken account of the rights of mothers to have an informed choice in the type of delivery which they wish to have with an expectation of a normal, natural childbirth wherever safe and possible, and for the delivery to take place in an accessible environment. In coming to this conclusion, we are aware that the vast majority of deliveries are normal and that other countries have developed a range of maternity services within protocols and co-ordinated arrangements which reflect the important issues of safety.

8.2 Problems of accessibility

We acknowledge that the abrupt way in which the Board was forced to cease maternity services in Monaghan and Dundalk prevented the normal planning which would precede such an action. Antenatal and post-natal clinics have subsequently been restored in both hospitals and the Board has made efforts to resolve many of the problems which arose.

Nevertheless, there are still potential problems as a consequence of the distances that mothers and mothers-to-be have to travel, given present road and traffic conditions.

8. THE MAJOR ISSUES CONSIDERED BY THE GROUP

"...with good co-ordinated arrangements to support the midwife-led units, the outcome in terms of safety in respect of the distant midwife-led units has been excellent."

Mr Richard Porter (see 6.5) told us that in his area the midwife-led unit furthest away from the consultant-led obstetric unit is approximately twenty-eight miles away and that transfer time during an average day would take 45-50 minutes. Taking into account waiting time for an ambulance, the longest transfer time could be an hour and ten minutes and the shortest would be 30-35 minutes. Mr Porter has emphasised that with good co-ordinated arrangements to support the midwife-led units, the outcome in terms of safety in respect of the distant midwife-led units has been excellent.

We have taken these views into account in formulating our recommendations to address the problems of accessibility arising from the present arrangements for the provision of maternity care in the region.

8.3 Population growth

We accepted statistical information for projected population growth in the North Eastern Health Board area and the expected consequences for the number of deliveries. This information is detailed in Appendix 4.

There is good evidence that there is a rapid population growth in parts of the Board's region. It is difficult to forecast the rate of this growth and we recognise that there is a need for the Board to make periodic reviews of the provision of maternity services to ensure that appropriate action is put in hand to supplement services when the need arises.

"There is good evidence to show that there is a rapid population growth in parts of the Board's region."

8.4 Quality issues

We received comments reflecting on the quality of existing maternity services provided in the region, particularly in respect of Our Lady of Lourdes Hospital, Drogheda. The issues related to quality of care; pressure on beds and early discharge policies, often requiring readmission; the lack of counselling services and problems of communicating effectively with patients. In interviews with former patients, we were told that there was a serious lack of confidence in the obstetric unit which persists among some members of the community and which arose because of their perceived poor treatment by the hospital. The Review Group was so concerned about these matters that the

"In general, we have been impressed by the commitment of medical and nursing staff in the area who have been providing maternity care under great pressure and often in difficult circumstances."

issues were raised at subsequent meetings with the hospital which was given an opportunity to say what had been done to improve these matters.

In a subsequent report, the hospital stated that they had introduced multidisciplinary clinical governance meetings in January 2000 and that evidence-based clinical guidelines and protocols have been revised and implemented. Clinical audit is now performed to monitor practice and to promote change. Audit results and clinical practice are compared with agreed standards and benchmarked against other hospitals, nationally and internationally.

Additionally, measures to assure quality practice on all wards have been introduced and results of customer satisfaction surveys are disseminated to all areas to help improve services. Actions have also been taken to improve communications and arrangements at antenatal clinics and parentcraft classes.

In general, we have been impressed by the commitment of medical and nursing staff in the region who have been providing maternity care under great pressure and often in difficult circumstances.

8.5 Midwife led units

Views were expressed to us supporting the concept of midwife led units and at the same time, some views opposed this development, especially at a distance from a consultant led unit. We therefore made extensive enquiries about such units and sought the views of representatives of midwives. We also referred to nursing policy documents issued in Ireland.

An Bord Altranais (2000) has given the WHO/ICM/IFGO definition of a midwife which is detailed in paragraph 7.5 of this report. Paragraph 3.2.2 of the An Bord Altranais report states that:

"Midwives felt that currently their scope of practice decision-making was centred on the way in which health services are delivered. Midwives have difficulty with the medicalisation of maternity services. They view the function of the midwife in maternity care as the normal care of women throughout pregnancy, labour and the postnatal period. Midwives outline that the current care they give is in contrast to their defined role and function. This can create differences of opinion between

midwives and obstetricians. The midwife feels that at times his/her role is only to facilitate, or is perceived as being only to facilitate, the obstetrician."

The Report of the Commission on Nursing (1998) states in Paragraph 10.10:

"Many midwives .... expressed the view that midwifery practice had become increasingly constrained in recent years and that midwives were becoming deskilled in the provision of maternity services."

The Commission goes on to say in Paragraph 10.11 that it "recognises that midwifery has an identity distinct from nursing. Midwives respond to the needs of pregnant women, many of whom are increasingly aware of the birth options available to them. Midwifery offers practitioners a unique opportunity for autonomous practice in the provision of health services to women."

"Midwifery offers practitioners a unique opportunity for autonomous practice in the provision of health services to women."

On the international scene, the Framework for Maternity Services in Scotland, issued in February 2001, sets out as one of its central principles that:

"Maternity services should provide a woman and family centred, locally accessible, midwife managed, comprehensive and effective model of care during pregnancy with clear evidence of joint working between primary, secondary and tertiary services".

The report continues under the heading of 'A Modern 21st Century Maternity Service' that midwives are the main providers of care to pregnant women, throughout pregnancy, childbirth and the postnatal period. Midwives provide clinical care and emotional support in both community and acute care settings and are usually the lead professional throughout pregnancy and childbirth for women with low risk pregnancies. Their expertise is in normal pregnancy, childbirth and postnatal care and in making referrals to appropriate medical professionals and others if they detect deviations from the normal.

In addition to these policy references, we are aware of the experience in operation of midwife-led units within the Royal Bath area where, for many years, the units have had excellent results under strictly agreed protocols and policies.

9. OUR VISION FOR THE FUTURE

"In our view, the North Eastern region should be self-sufficient as far as possible in providing maternity and child care, offering a comprehensive range of services."

We stated at the outset that the key principles behind the Review Group's philosophy are to develop a woman-centred, quality service which is safe, accessible and sustainable.

We have looked carefully at the guidance adopted for maternity services in other places, particularly the United Kingdom and we have accepted the following broad themes to form the basis of our vision.

- Safety and evidence-based care for mother and baby must remain the foundation of an effective maternity service
- Pregnancy and childbirth are normal physiological processes in a woman's life
- Maternity services must deliver a woman and family centred approach to care and support, planned in partnership with the woman
- Maternity services should be essentially community based and midwife managed, wherever possible, with an emphasis on continuity of care
- Maternity services should be integrated and seamless from primary to secondary care, with emphasis on choice, teamwork and effective communication

In our view, the North Eastern region should be self-sufficient as far as possible in providing maternity and child care, offering a comprehensive range of services. These services should include midwife led units both within obstetric hospital settings and within acute hospital settings and consultant led obstetric units supported by paediatric services in the region which include a neonatal intensive care unit, special care baby units and ambulatory paediatric services at Dundalk and Monaghan.

The distribution of these services should facilitate access for mothers-to-be including the provision of ante-natal services.

"Considerable work is needed to plan and implement this vision."

Not all of these services can be provided on each site. For example, neonatal intensive care is a specialist activity, requiring a high concentration of trained medical and nursing staff. Realistically within the region, this service can only be sustained at one centre.

The principle behind our thinking is that all these services will be available within the region and the mother-to-be will be guided in making her choice of delivery by continuous assessment during pregnancy which will highlight the category of risk to the mother and her baby. We believe that mothers in the low risk category should be able to choose if they wish delivery in a more accessible midwife-led unit.

Our vision has had to be set in the context of a rising number of births in the region, particularly affecting Our Lady of Lourdes Hospital, Drogheda which is forecasting over 3,000 births in this calendar year. Further increases will arise in the future from the large number of asylum seekers served by the hospital and significant population shifts into the catchment area. Additionally, the major maternity units in Dublin have announced that they cannot deal with the increasing levels of work and they look to the adjoining regions to meet their own workloads.

Considerable work is needed to plan and implement this vision.

We outline in Section 11 our recommendations and how this vision should be taken forward.

10. RECOMMENDATIONS

"Our vision of the future maternity services in the region requires far-reaching change in organisational arrangements and substantial investment."

Our vision of the future maternity services in the region requires far-reaching change in organisational arrangements and substantial investment. It is abundantly clear to us that existing maternity services have worked under increasing pressure and have been maintained by the commitment and dedication of medical and nursing staff. Our prime objective is to ensure that safety, protocol driven and evidence-based care for mother and baby remains the foundation of an effective maternity service.

10.1 Organisational Arrangements

We believe that a first step should be the establishment of a Task Force whose function would be to develop our recommendations in terms of the policies and protocols to be put in place; to process key appointments which have to be made urgently and to plan adaptations which are needed to the existing buildings.

In our view the region, in conjunction with hospital groups, should determine the protocols to be adopted to achieve a safe, quality comprehensive and integrated service. Delivery is at hospital group level and typically, this is overseen in other places by lead clinicians/speciality co-ordinators in obstetrics and paediatrics. We consider that a designated midwife should work with the lead clinicians. We wish to ensure that there is a clear pathway for the submission of advice to the Board on maternity matters and so we feel that one of the specialty co-ordinators in obstetrics/paediatrics should be given responsibility for direct communication to the Board as a regional specialty advisor.

We emphasise that constant review of the protocols is necessary to ensure their satisfactory operation and the safety of the service.

We were told that the operation of integrated and interdependent maternity services require rigorous implementation of the key protocols of assessment, inter-hospital transfer arrangements and emergency procedures including the provision of dedicated emergency ambulance services at each location.

"Representatives of consumer organisations would have the opportunity to be involved in consultation about present operations and future developments"

We consider that a region-wide Consumer Committee for Maternity and Childcare Services should be put in place. Representatives of consumer organisations would have the opportunity to be involved in consultation about present operations and future developments and should be able to assess the quality of the services being provided.

The organisational arrangements must provide for multidisciplinary clinical audit.

Public transport to the hospital sites is a concern. We believe that there is scope for the Board's Task Force to work with transport agencies to overcome some of the practical difficulties which face people without their own transport. There is a clear need for daily regular inter-hospital transport between Dundalk/Drogheda, Monaghan/Cavan to cover visiting times as well as outpatient appointments, etc.

10.2 Facilities/services required

Facilities/services in the region should include:

- A Level 3 obstetric unit based at Our Lady of Lourdes Hospital, Drogheda, together with the Regional Neonatal Intensive Care Unit.

The services provided in the unit will include:

- all pregnancy complications cared for including insulin dependent diabetes, extreme prematurity and multiple pregnancy
- rapid access to adult intensive care facilities;
- neonatal intensive care for all viable birthweights and gestational ages
- epidural anaesthesia should be available to over 80% of women having caesarean section
- obstetric ultrasound to tertiary care standards
- perinatal audit with annual statistics and audit to a set of agreed criteria
- 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.

The services provided in the unit will be as for a Level 3 unit but with the following exceptions:

- there is no long-term neonatal intensive care provision
- women expected to deliver before 32 weeks of gestation with an estimated foetal weight of 1500 grams or less must be transferred to Level 3 obstetric care wherever this is possible and safe
- women with complicated pregnancies such as insulin dependent diabetes, some cases of severe pregnancy induced hypertension and high order multiple pregnancies and mono-chorionic twin pregnancies, must be transferred to Level 3 obstetric care.

- Midwife-led units in Cavan and Drogheda, with the phased opening of units at Dundalk and Monaghan as soon as possible, given that steps need to be taken to meet the requirements of midwives and to provide them with adequate support. These units will permit community midwifery development and will give greater opportunity for the option of home births. Because of the increasing pressure of work, a midwife-led unit should also be established at Navan Hospital as soon as this is judged to be necessary.

The services provided at these units will include:

- antenatal, intrapartum and postnatal care to women who fulfil a set of criteria used to define low intrapartum risk

No obstetric anaesthesia or facilities for caesarean section are available at this level.

- Provision of a midwifery service in the community, separate from the public health nursing service and which will provide a home birth team linked to the midwife-led units.
- Provision of shared care in the community between the general practitioner and the maternity services. This provision acknowledges the role of the general practitioner in an integrated maternity service, with the emphasis on patient choice, effective communication, mutual professional respect and promotion of teamwork.
- Development of an ambulatory paediatric outpatient service in Dundalk and Monaghan to include:
- primary care paediatrics
- community paediatrics
  - *child development/disability*
  - *social paediatrics*
  - *health promotion*
- accident and emergency consultations
- emergency clinics
- day care paediatrics
- outpatient clinics
- hospital at home schemes
- paediatric community nursing services
- An inter-hospital transport service with the capacity to deal with maternal/baby emergencies.

10.3 Staffing requirements

There is a serious shortfall of staff at consultant level in a number of specialties. There is also a shortage of midwives and trained neonatal care nurses. Given recruitment problems, it will take time to reach the levels of staffing recommended by medical and nursing bodies related to work activity. However, the implementation of our proposals requires a number of appointments to be made urgently and it must be stressed that these appointments are also needed to sustain the present level of maternity and childcare services.

10.3.1 Obstetrics

In the Louth Meath Hospital Group, there are four consultant obstetric posts with one locum tenens consultant. The increase in births requires a minimum of six substantive consultant obstetrician posts.

In the Monaghan Cavan Group, there are two consultant obstetric posts with two locum tenens appointments.

There is a requirement for three substantive consultant obstetric posts.

10.3.2 Paediatrics

There should be ten paediatric consultant posts in the region, as follows:

- Two general paediatricians; two general paediatricians with an interest in community paediatrics (to promote developments in ambulatory care (see page 37) in Louth Meath Hospital Group) and two neonatologists to be based at Our Lady of Lourdes Hospital, Drogheda. The current establishment is two general paediatricians and one neonatologist.
- The Monaghan Cavan hospital group should have two general paediatricians and two general paediatricians with an interest in community paediatrics (to promote developments in ambulatory care in this area). There are currently two consultant paediatricians based at Cavan General Hospital.

There is a need for a 30-cot unit of 10 Intensive Care and 20 special care cots at Our Lady of Lourdes Hospital, Drogheda. Currently, the unit is planned to work at the level of sixteen cots which includes one intensive care cot, but because of pressure on the service, it has been necessary to run the unit at the higher level of twenty-four cots with up to five of them intensive care. This position emphasises the need for urgency in processing the consultant paediatric posts.

There is a shortage of neonatal care nurses. Currently, there are 20.5 in post at Our Lady of Lourdes Hospital, Drogheda and on the basis of the recommended

30-bed unit, the future establishment of neonatal care nurses should be in the region of 60.

We must leave to the Task Force appointed by the Board the job of identifying the phasing of the necessary increase in midwifery and neonatal nursing staff, having regard to the establishment of midwife-led units in the region and the present shortfall of nursing staff.

10.4 Training

Our Lady of Lourdes Hospital, Drogheda has established links with the Royal College of Surgeons Medical School, Dublin and with Trinity College, Dublin for the midwifery programmes of education. The pilot entry to midwifery course in conjunction with the Rotunda Hospital, Dublin, was introduced in 2000 and midwives from the unit facilitate the course and act as mentors to the students.

The hospital also participates in the fifteen month nursing neonatal course and is permitted to place nursing staff on the course. It is recommended that Our Lady of Lourdes Hospital should be approved as a training centre to allow placement of students undertaking the course.

The Scottish Framework for Maternity Services sets out detailed guidance for training of clinical, nursing and ambulance staff in resuscitation and other techniques and we commend these recommendations to the Board for adoption.

10.5 Cross border co-operation

We recommend that, pending the development of the integrated maternity service, mothers-to-be in geographical areas accessible to Newry, Enniskillen and Craigavon should have the right to choose the maternity services of these acute hospitals. The Board should negotiate terms with the appropriate health and social services trusts in Northern Ireland under the CAWT arrangement (Co-operation and Working Together).

We believe that, in the light of the present distribution of maternity services in the region, there is not a demand arising in proximate areas in Northern Ireland to use the Board's facilities in Monaghan and Dundalk. It is thought, however, that as an integrated maternity service develops, it will attract cross-border support in the light of its comprehensiveness and the diversity and choice of service it offers.

10.6 Accommodation

We recommend that action should be taken as quickly as possible to upgrade maternity accommodation in Monaghan and Dundalk in preparation for the introduction of the midwife-led service. There is also a need for minor adaptations in Drogheda and Cavan. We are particularly concerned about the accommodation previously used for maternity services in Monaghan. We urge the Board to consider options for its replacement on the existing site in accordance with the Board's 1998 framework document.

10.7 Regional centre

We consider 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 arrangements with education centres in Dublin. We commend to the Board the present development of a lectureship in obstetrics (associated with the Royal College of Surgeons) in the hospital in the belief that such links will improve the quality of services and will help with the recruitment of staff. We further recommend that, similarly, a lectureship in midwifery should be pursued to undertake research in practice.

10.8 Communication

We urge that steps are taken at hospital level to improve communication with parents and parents-to-be. We are aware that much work has been done at other hospitals to develop patient-friendly policies which recognise and take account of their anxieties. We recommend that maternity hospitals consider this matter carefully and introduce appropriate policies and measures to help mothers. We further recommend that the Board monitors on an ongoing basis the action taken by hospitals to achieve more effective communication.

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

10. RECOMMENDATIONS

10.9 Population growth

There is clearly much potential for population growth in the region and we recommend that the Board makes formal arrangements within its management structure to review maternity services at intervals. The frequency of this review is for the Board to decide in the light of its awareness of population changes and pressures on services. Given the population projections for County Louth, there is a likelihood that maternity work at the Louth County Hospital could, in the future, warrant classification as a Level 2 obstetric unit.

10.10 Gynaecology

While it is not within our remit to review gynaecology services, the close links with obstetrics has meant that gynaecology services have been affected by the withdrawal of consultant-led services in Monaghan and Dundalk. Recognising the importance of retaining gynaecology services in Monaghan and Dundalk, we strongly recommend that the Board must consider the distribution and type of gynaecology services to be provided and ensure that people are made aware of its decisions.

11. ACKNOWLEDGEMENTS

We thank everyone who sent a written submission or who met with us to present their views.

We acknowledge the support provided to us throughout our task by officers of the North Eastern Health Board, particularly Mr Jim Reilly, Ms Elaine Ryan and Dr Fenton Howell, and staff in hospitals across the region.

Members pay particular tribute to the work of our Executive Secretary, Mrs Ingrid Freeburn, who has given commitment and enthusiasm to the project and whose organisational skills have ensured the efficient completion of our task.

Mrs Ingrid Freeburn

12. SIGNED STATEMENT

In submitting this report to the Chief Executive Officer of the Board, we confirm that all the members of the Review Group are unanimously committed to its recommendations. We are confident that the report provides a vision for an innovative, accessible, safe and sustainable comprehensive maternity service of the highest quality for the North Eastern Health Board region.

Mr Patrick Kinder, Chairperson

Professor John Bonnar

Councillor Declan Breathnach

Councillor Patrick Conaty

Mrs Marie Devlin

Mrs Mary Duffy

Mrs Ann Farrell

Ms Barbara Folan

Councillor Brendan Hughes

Dr Patricia Kennedy

Dr Brian McDonagh

Dr John Madden

Councillor James Mangan

Dr David O'Flaherty

Dr Michael Scott

PUBLIC NOTICE: APPENDIX 1

PUBLIC NOTICE

Review of Maternity Services

The North Eastern Health Board following consideration of the Report of the Review Group, on Maternity Services chaired by Mr. Dermot Condon, which was published in November 2000, agreed to a Further Independent Review with a broader remit. This Further Review group has now been established with the following terms of reference:-

- to investigate fully all the options in relation to maternity services in the area of the North Eastern Health Board in the light of current practice, knowledge and developments, both here and abroad and with particular attention to the development of maternity services in the region in response to the potential for cross-border co-operation in maternity services delivery and the projected demographics in Counties Louth, Cavan, Meath and Monaghan and cognisant of the requirements of spatial planning, as anticipated in the Government's National Development plan and
- to involve in this process obstetricians, anaesthetists, paediatricians, senior nurses and midwives, general practitioners, other expert opinion and representatives of user groups in the local communities and to accommodate, as far as is possible, consultation with the wider public, our service users and
- to seek appropriate expert advice from outside the region.
- to report to the Chief Executive Officer no later than 7th September, 2001.

The Review Group wishes to invite interested individuals, groups, or organizations to make submissions for consideration by the group. The Review Group would particularly like to hear the views of mothers and potential mothers about the type of maternity services they wish to have for the future.

The Board has decided a timescale within which the review group should complete their task and therefore it is necessary to ask for submissions to be made as quickly as possible but no later than 30th June 2001.

Copies of the "Condon Report" are available from the North Eastern Health Board.

Submissions can be made by writing directly to:

Mr. Pat Kinder,
Chairperson,
Maternity Services Review Group,
C/O North Eastern Health Board, Kells, Co. Meath.

FURTHER ADVERTISEMENT: APPENDIX 2

PUBLIC NOTICE

Review of Maternity Services

The Maternity Services Review Group wishes to advise that the closing date for receipt of submissions for consideration by the group has been extended from 30 June (as advertised previously) to 21st July, 2001. The Review Group wishes to invite interested individuals, groups, or organizations, who have not yet made a submission to now make their submissions. The Review Group would particularly like to hear the views of mothers and potential mothers about the type of maternity services they wish to have for the future.

Submissions can be made by writing directly to:

Mr. Pat Kinder,
Chairperson,
Maternity Services Review Group,
C/O North Eastern Health Board, Kells, Co. Meath.

Submissions can also be faxed or e-mailed.

SUBMISSIONS: APPENDIX 3

WRITTEN SUBMISSIONS RECEIVED

Ahern, D, TD	Office of the Minister, Social, Community & Family Affairs
Anonymous (8)	No addresses given
Arnold, Ms T	Co Down
Baldwin, Ms D	Co Louth
Bannon, M	Co Armagh
Begley, Ms C	Co Louth
Begley, Ms J	Co Louth
Bellew, Mr M, UDC MCC	Co Louth
Bolger, Ms R	Co Louth
Bolton, Ms A	Co Louth
Bothwell, A	Co Louth
Bothwell, D	Co Louth
Bothwell, Ms D	Co Louth
Bothwell, Ms S	Co Louth
Bowyer, Mr E	Newry & Mourne Health & Social Services Trust
Breathnach, D & Savage, P	Co Louth
Burlingham, Ms E	No address given
Burlingham, Ms M	Co Louth
Byrne, Mr S, MCC DUDC	Co Louth
Byrne, Ms L	Co Louth
Callan, Ms A	Co Louth
Callan, Ms A	No address given
Callan, Ms G	No address given
Cantan, P	No address given
Caraher, Ms M	Co Louth
Casey, Ms M	No address given

Cash, Ms C	Co Louth
Cheevers, Ms P	No address given
Clarke, Dr T	The Royal College of Physicians of Ireland
Clarke, Mr K	Co Louth
Clarke, Mrs	Co Louth
Condell, Dr D	Cavan General Hospital
Conlon, Ms M	No address given
Connolly, Ms B	Co Monaghan
Connor, Ms M	Co Louth
Conway, Ms D	No address given
Coyle, M & Ryan, J	Impact, Monaghan Branch
Crowley, Dr	Association of General Practitioners, Ireland
Cullen, Dr B	Co Louth
Culligan, Ms S	Co Louth
Cummins, Ms NJ	Faculty of Nursing and Midwifery, R.C.S.I.
Daly, Mr G	No address given
Daly, Ms M	No address given
Deane, Ms G	Co Louth
Devlin, Ms R	No address given
Duffy, Mr D	I.H.C.A., Dublin
Duffy, Dr I	On behalf of General Practitioners in Monaghan town
Duffy, Mr & Mrs	Co Louth
Duffy, Mrs M	Patient Focus
Feely, Ms B	Dundalk Institute of Technology
Fiddis, Ms V	Royal College of General Practitioners, Northern Ireland
Fox, Ms J	Co Louth
Fraser, Ms CM	Co Monaghan

SUBMISSIONS:
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Gaffney, Ms S	No address given
Garvey, Ms K	No address given
Gavan, Dr R	Co Meath
Glees, Mrs M	No address given
Gordon, Ms S	Co Louth
Grehan, Dr M	Co Louth
Grogan, Ms P	Co Monaghan
Hamill, Ms A	Co Louth
Hamilton, Mr P	No address given
Harden, Mr J	Monaghan General Hospital Development Committee
Hogan, Dr and Henry, Dr	Co Louth
Holden, Ms M	Irish Countrywomen's Association
Hourihan, Mr F	Irish Medical Organisation
Hughes, Ms A	Co Monaghan
Hughes, Ms M	Co Louth
Hughes, Mrs R	Co Monaghan
Irvine, Mrs E	Co Down
Kernan, Ms C	Co Louth
Kilcommins, Ms P	Co Louth
Kinney, Mrs N	Co Louth
Len, Ms T	Co Louth
Lenache, Ms M	No address given
Lennon, Dr F	Our Lady of Lourdes Hospital
Leonard, Senator A MCC	Co Monaghan
McAnespie, Ms B	Co Monaghan
McArdle, A	No address given
McArdle, Ms A	Co Louth
McArdle, Ms E	No address given

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

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McCabe, Ms J	Co Louth
McCabe, Ms L	Co Louth
McCabe, Ms N	Co Louth
McCrane, Mrs A	Co Louth
McCumiskey, Ms B	Co Louth
McCutcheon, Ms M	Co Louth
McDermott, Ms K	No address given
McDowell, Dr C & Connolly, Dr P	Our Lady of Lourdes Hospital
McElroy, Ms D	No address given
McElroy, Ms K	Co Monaghan
McElvaney, Mr H	on behalf of Fine Gael Members of Monaghan County Council
McEneaney, Ms M	Co Louth
McGahon, Ms M	Co Louth
McGuigan, Ms M	Co Monaghan
McGuill, Mr M	Co Louth
McGuinness, Mr J	Dundalk Urban District Council
McGuire, Ms G	Co Monaghan
McKenna, Mr & Mrs	Co Monaghan
McKenna, Mr & Mrs	Co Monaghan
McKenna, Ms U	Dochas for Women Ltd, Co Monaghan
McLoughlin, Ms A	Co Louth
McMahon, Ms E	Co Monaghan
McMahon, Ms P	Co Monaghan
McNally, Ms F	Cavan General Hospital
McQuaid, Mr & Mrs (2)	Co Monaghan
Magill, Ms S	Co Louth
Mangan, Dr N	Co Louth

SUBMISSIONS:
APPENDIX 3

Martin, Ms S	Louth Meath Health Group
Meghan, Ms A	No address given
Meleady, Ms M	Navan I.C.A.
Minto, Mr N	Co Louth
Monahan, F	No address given
Moran, Ms P	Co Louth
Morgan, Mr A	Louth County Hospital Action Group
Morrissey, Ms A	No address given
Morton, Ms O	No address given
Muckian-Ryan, Ms D	Co Louth
Murphy, Ms J	No address given
Murphy, Ms MB	Co Monaghan
Murphy, Ms S	Co Louth
Murphy, Ms S	Monaghan Urban District Council
Nash, Ms K	No address given
Ni Chinneartai, Ms N	Co Meath
Nicholson, Dr A	Our Lady of Lourdes Hospital
O'Brien, Dr S	Co Louth
O'Brien, Mr H	The Union of Retail, Bar and Administrative Workers
O'Calloghan, Ms J	No address given
O'Calloghan, Mr N	No address given
O'Caolain, Mr C TD	Cavan/Monaghan Constituency Office
O'Donoghue, Mr E	An Bord Altranais
O'Hanlon, Mrs M	Co Louth
O'Hanlon, Dr R, TD	Co Monaghan
O'Hare, Dr MF; Sim, Dr D; De Courcy Wheeler, Dr R; McKinney, Dr K	Newry and Mourne Health & Social Services Trust

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Owens, Ms K	Co Louth
Quigley, Ms A	Co Louth
Rafferty, Mrs J	No address given
Rafferty, Ms L	Ait na nDaoine Community Development Project
Rafferty, Ms L	Community Parenting
Reilly, Ms P	Co Louth
Rice, Ms D	No address given
Rogers, A	No address given
Secretary, Sinn Fein	Co Louth
Seevens, TG	No address given
Sharkey, Ms K	Dundalk Branch I.N.T.O.
Stewart, D	Co Louth
Stewart, Mrs	Co Louth
Stuart-Black, E	Co Monaghan
Sullivan, Dr A	Co Cavan
Suresh, Ms P	Co Louth
Taffe, Ms Y	Co Louth
Thornton, Ms E	No address given
Ua Conchubhair, Dr S	Association of General Practitioners
Van Haaster, Dr J	Cavan General Hospital
Waller, Mr G	No address given
Waller, Ms G	No address given
Walsh, P	No address given
Warnock, Ms K	Co Louth
Whately, Dr J	Co Louth
Woods, Ms B	Co Louth
Woods, Ms M	Co Louth

ORAL SUBMISSIONS HEARD

9 June, Cavan General Hospital

Dr Alan Finan & Dr Ann Leahy, consultant paediatricians, Cavan General Hospital

Dr Ahmed Hussein & Dr Hussein Shiddo, consultant obstetricians & gynaecologists, Cavan General Hospital

Ms Patricia Hughes, maternity services manager, Cavan General Hospital

Dr Louis Courtney, consultant obstetrician & gynaecologist, Cavan General Hospital

Mr Kevin Molloy, general manager, Cavan/Monaghan Hospitals Group

Ms Geraldine McRory & Ms Mary Lynch, midwives, Cavan General Hospital

7 July, Louth County Hospital, Dundalk

Ms Nuala Rafferty, staff nurse, on behalf of nursing staff of Louth County Hospital

Dr Mary Grehan, Mr Arthur Morgan & Mr Eugene Deane, representing Louth County Hospital Action Group

21 July, Monaghan General Hospital

Dr Pillay, consultant physician, Monaghan General Hospital

Dr Rommel, consultant obstetrician & gynaecologist, Monaghan General Hospital

Sister Brenda, matron, Monaghan General Hospital

Ms Mary Flora and midwifery colleagues, Monaghan General Hospital

Mr Michael Flood & colleagues representing concerned staff of Monaghan General Hospital

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21 July, Hillgrove Hotel, Monaghan

Four representatives of Patient Focus

23 July, Louth County Hospital

Ms Catherine Sheridan and midwifery colleagues from Louth County Hospital

11 August, Fairways Hotel, Dundalk

Dr T O'Callohan and colleagues representing the medical board, Louth County Hospital

11 August, Our Lady of Lourdes Hospital, Drogheda

Mr Declan Collins, acting general manager, Our Lady of Lourdes Hospital

Mrs Mary Duff, director of nursing, Our Lady of Lourdes Hospital

Dr Siobhan Gormley, consultant paediatrician, Our Lady of Lourdes Hospital

Dr John Ryan, chairman of medical board, Our Lady of Lourdes Hospital

Mr Finian Lynch, consultant obstetrician & gynaecologist, Our Lady of Lourdes Hospital,

and other key staff of the hospital.

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In the light of the representations made to us about population growth and consequent increased demands on maternity services, we sought information from the North Eastern Health Board about population projections. The Board presented us with a paper setting out these statistics.

We noted that these projections differed from housing projections at County Council level. However, we remain of the opinion that, pending the Census to be undertaken in 2002, it is not possible to reconcile these differences.

Elsewhere in the report, we have stressed the need for the Board to undertake periodic reviews to take account of pressures on maternity services in the region.

The information provided by the Board is on the following pages.

Population Projections and related issues for the North Eastern Health Board: 2001-2031

Introduction

Population projections are important for those who plan for service development, as they need to have some idea as to what the future population profile will bring. Population projections are carried out centrally by the Central Statistics Office (CSO) based on existing census data and their expectations for future mortality, fertility and net migration rates. In July 1999 they reported "Population and Labour Force Projections 2001-2031". The Department of Public Health Medicine extrapolated data from that report for the North Eastern Health Board (NEHB) region and forwarded it to all Senior Managers within the NEHB. At that time the CSO only prepared population projections at the national level. Since then the CSO have done more extensive work on their projections and in June 2001 they published regional population projections for 2001-2031. Regional Authorities are as set out in the Local Government Act 1991 and include the following counties:

Border - *Cavan*, Donegal, Leitrim, *Louth*, *Monaghan*, Sligo.
Mid-East - Kildare, *Meath*, Wicklow.
Dublin - Dublin County Borough, Dun Laoghaire/Rathdown, Fingal, South Dublin

Midland - Laois, Longford, Offaly, Westmeath.
West - Galway County Borough, Galway County, Mayo, Roscommon.
Mid-West - Clare, Limerick County Borough, Limerick County, Tipperary North Riding.
South-East - Carlow, Kilkenny, Tipperary South Riding, Waterford County Borough, Waterford County, Wexford.
South-West - Cork County Borough, Cork County, Kerry.

The projections are based on assumptions with respect to regional fertility levels, mortality trends and international migration to and from each region. These are consistent with those used at a national level. In addition a single set of assumptions has been made concerning movements between regions. The CSO perform their calculations based on different combinations of the assumptions and produce data for six potential population scenarios.

However, they recognise that since 1996 a pattern has emerged which makes one scenario much more likely than any of the other five. This scenario (M1F2) assumes that net immigration will continue up to 2006, a steady state to 2011, followed by net emigration thereafter to 2031 and that total fertility will remain constant at its 1998 level to 2001, decrease to 1.75 by 2011 and remain constant thereafter.

Under this scenario, which largely assumes the continuation of recent demographic trends, the main features of the regional projections are:

- The Irish population is expected to increase by 940,000 by 2031;
- Over four fifths of the projected population increase of 940,000 between 1996 and 2031 will arise in the Dublin and Mid-East regions;
- The population of the Dublin region is projected to increase by over half a million persons in the period to 2031;
- Births will exceed deaths in each of the Regional Authority areas with the excess being most pronounced for Dublin (+315,400) and the Mid-East (+81,200);
- Apart from the Midlands, which is projected to lose 10% of its population, each Regional Authority area will experience population growth over the 35-year period 1996-2031, although in the case of the South-East the projected increase will be less than 1%;
- Dublin will be the fastest growing area (+56.0%), followed by the Mid-East (+49.7%). These areas will grow due to natural increases and international migration and will gain population through internal migration (people moving between the regions) from the remaining six regions;
- All regions are projected to benefit from external migration (i.e. there will be more immigrants into these regions than emigrants from them). The greatest gainers will be Dublin (+205,200) and the West (+47,900).

REPORT OF THE MATERNITY SERVICES REVIEW GROUP TO THE NORTH EASTERN HEALTH BOARD

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Implications of these Population Projections for the North Eastern Health Board region

Unfortunately, the Central Statistics Office does not provide a breakdown at individual county level. The population in the North East is distributed between two Regional Authority areas. However, it is reasonable to take the predictions for each area and apply them to the baseline population of the counties within that region on an aggregated basis in order to project forward as to the likely scenarios in the future. Accordingly the assumptions for the Border region have been applied to the baseline-combined population of Louth, Cavan and Monaghan in order to project forward for that area. In addition a similar exercise was carried out applying the assumptions for the Mid-East region to the baseline Meath population in 1996 in order to project forward. The following three tables outline the projected population for the Meath area (Table 1), the Louth, Monaghan, Cavan area (Table 2) and both combined (Table 3) to give a profile of the expected North Eastern Health Board population over the next 30 years. Figures 1 to 3 show the data graphically. Considerable caution is advised in using this data as the assumptions, although much more robust than in the previous release, were generated for the regions and some county variation could occur. However, they do give some guidance as to what might happen in the future.

As can be seen from the tables there is a marked difference in the projected growth of the population in the two areas. The 0-14 and the 15-24 age groups are projected to drop markedly in the Border area, whilst there is projected to be an increase in the Meath area. Sustained growth is expected in the 45+ age group in both areas, especially for those 65+, but it is more pronounced in the Meath area where the actual growth is expected to exceed that of the combined Border region.

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It is also worth noting, that in line with CSO expectations, the total population in the NEHB (Table 3) is expected to grow, albeit at a much greater pace in Meath. At the 1996 census the population of Meath was 36% of the NEHB total, this is projected to rise to 39% by 2006, 40% by 2001 and 45% by 2031.

Of particular interest is the projected female population in the (20-39) age group. This age group accounts for over 90% of all births. In the period 1996-2031 the number of women in this age group is expected to rise until 2009 in the Border counties and until 2012 in Meath (Figure 4). Thereafter it is expected that the numbers in this group will decline with that decline-taking place more quickly in the border region than in Meath.

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Table 1

NEHB Population Projections M1F2 scenario - Actual and percentage changes from 1996

Data for County Meath based on regional estimates from the Central Statistics Office

Projected Population

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14	28607	28134	29027	30231	30215	29520	28758	28261
15-24	18438	19523	18520	17110	17636	18774	18924	18542
25-34	14502	16494	18603	19124	17747	16349	16797	17892
35-44	16418	18173	19537	21426	23416	23796	22328	20823
45-54	13301	15905	17749	19437	20708	22554	24579	24989
55-64	7840	10304	13697	16261	18087	19794	21142	23063
65-74	6156	6433	7404	9713	12814	15195	17037	18769
75+	4470	4982	5369	5869	6795	8780	11559	14337
Total	**109732**	**119948**	**129907**	**139171**	**147418**	**154762**	**161124**	**166676**

Actual change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-473	420	1624	1608	913	151	-346
15-24		1085	82	-1328	-802	336	486	104
25-34		1992	4101	4622	3245	1847	2295	3390
35-44		1755	3119	5008	6998	7378	5910	4405
45-54		2604	4448	6136	7407	9253	11278	11688
55-64		2464	5857	8421	10247	11954	13302	15223
65-74		277	1248	3557	6658	9039	10881	12613
75+		512	899	1399	2325	4310	7089	9867
Total		**10216**	**20175**	**29439**	**37686**	**45030**	**51392**	**56944**

% change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-1.7	1.5	5.7	5.6	3.2	0.5	-1.2
15-24		5.9	0.4	-7.2	-4.3	1.8	2.6	0.6
25-34		13.7	28.3	31.9	22.4	12.7	15.8	23.4
35-44		10.7	19.0	30.5	42.6	44.9	36.0	26.8
45-54		19.6	33.4	46.1	55.7	69.6	84.8	87.9
55-64		31.4	74.7	107.4	130.7	152.5	169.7	194.2
65-74		4.5	20.3	57.8	108.2	146.8	176.8	204.9
75+		11.5	20.1	31.3	52.0	96.4	158.6	220.7
Total		**9.3**	**18.4**	**26.8**	**34.3**	**41.0**	**46.8**	**51.9**

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Table 2

NEHB Population Projections M1F2 scenario - Actual and percentage changes from 1996

Data for Counties Louth, Cavan, Monaghan combined based on regional estimates from the CSO

Projected Population

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14	49069	44998	43270	42872	41583	39167	36204	33249
15-24	32672	34754	31961	27522	25627	25645	25075	23760
25-34	26444	28076	31485	32710	29065	24472	22539	22553
35-44	26153	26972	27210	28429	31309	32180	28676	24279
45-54	22143	24889	26134	26858	26944	28032	30847	31758
55-64	15756	17778	21368	24012	25225	25972	26174	27325
65-74	13991	13172	13510	15387	18569	20914	22205	23060
75+	10195	10603	10578	10574	11104	12677	15361	17831
Total	196423	201241	205515	208364	209426	209059	207081	203814

Actual change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-4071	-5799	-6197	-7486	-9902	-12865	-15820
15-24		2082	-711	-5150	-7045	-7027	-7597	-8912
25-34		1632	5041	6266	2621	-1972	-3905	-3891
35-44		819	1057	2276	5156	6027	2523	-1874
45-54		2746	3991	4715	4801	5889	8704	9615
55-64		2022	5612	8256	9469	10216	10418	11569
65-74		-819	-481	1396	4578	6923	8214	9069
75+		408	383	379	909	2482	5166	7636
Total		4818	9092	11941	13003	12636	10658	7391

% change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-8.3	-11.8	-12.6	-15.3	-20.2	-26.2	-32.2
15-24		6.4	-2.2	-15.8	-21.6	-21.5	-23.3	-27.3
25-34		6.2	19.1	23.7	9.9	-7.5	-14.8	-14.7
35-44		3.1	4.0	8.7	19.7	23.0	9.6	-7.2
45-54		12.4	18.0	21.3	21.7	26.6	39.3	43.4
55-64		12.8	35.6	52.4	60.1	64.8	66.1	73.4
65-74		-5.9	-3.4	10.0	32.7	49.5	58.7	64.8
75+		4.0	3.8	3.7	8.9	24.3	50.7	74.9
Total		2.5	4.6	6.1	6.6	6.4	5.4	3.8

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Table 3

NEHB Population Projections M1F2 scenario. Actual and percentage changes from 1996

Data for the NEHB based on regional estimates from the Central Statistics Office

Projected Population

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14	77676	73132	72297	73103	71797	68687	64961	61510
15-24	51110	54277	50480	44632	43263	44419	43999	42302
25-34	40946	44570	50088	51834	46812	40822	39336	40445
35-44	42571	45145	46747	49855	54724	55976	51005	45101
45-54	35444	40794	43882	46294	47652	50586	55426	56747
55-64	23596	28082	35066	40273	43312	45765	47316	50387
65-74	20147	19605	20914	25100	31383	36109	39243	41829
75+	14665	15585	15947	16443	17900	21457	26920	32168
Total	306155	321189	335422	347535	356844	363821	368205	370489

Actual change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-4544	-5379	-4573	-5879	-8989	-12715	-16166
15-24		3167	-630	-6478	-7847	-6691	-7111	-8808
25-34		3624	9142	10888	5866	-124	-1610	-501
35-44		2574	4176	7284	12153	13405	8434	2530
45-54		5350	8438	10850	12208	15142	19982	21303
55-64		4486	11470	16677	19716	22169	23720	26791
65-74		-542	767	4953	11236	15962	19096	21682
75+		920	1282	1778	3235	6792	12255	17503
Total		15034	29267	41380	50689	57666	62050	64334

% change from 1996

Age	1996	2001	2006	2011	2016	2021	2026	2031
0-14		-5.8	-6.9	-5.9	-7.6	-11.6	-16.4	-20.8
15-24		6.2	-1.2	-12.7	-15.4	-13.1	-13.9	-17.2
25-34		8.9	22.3	26.6	14.3	-0.3	-3.9	-1.2
35-44		6.0	9.8	17.1	28.5	31.5	19.8	5.9
45-54		15.1	23.8	30.6	34.4	42.7	56.4	60.1
55-64		19.0	48.6	70.7	83.6	94.0	100.5	113.5
65-74		-2.7	3.8	24.6	55.8	79.2	94.8	107.6
75+		6.3	8.7	12.1	22.1	46.3	83.6	119.3
Total		4.9	9.6	13.5	16.6	18.8	20.3	21.0

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Figure 1 - Meath Population: 1996 - 2031

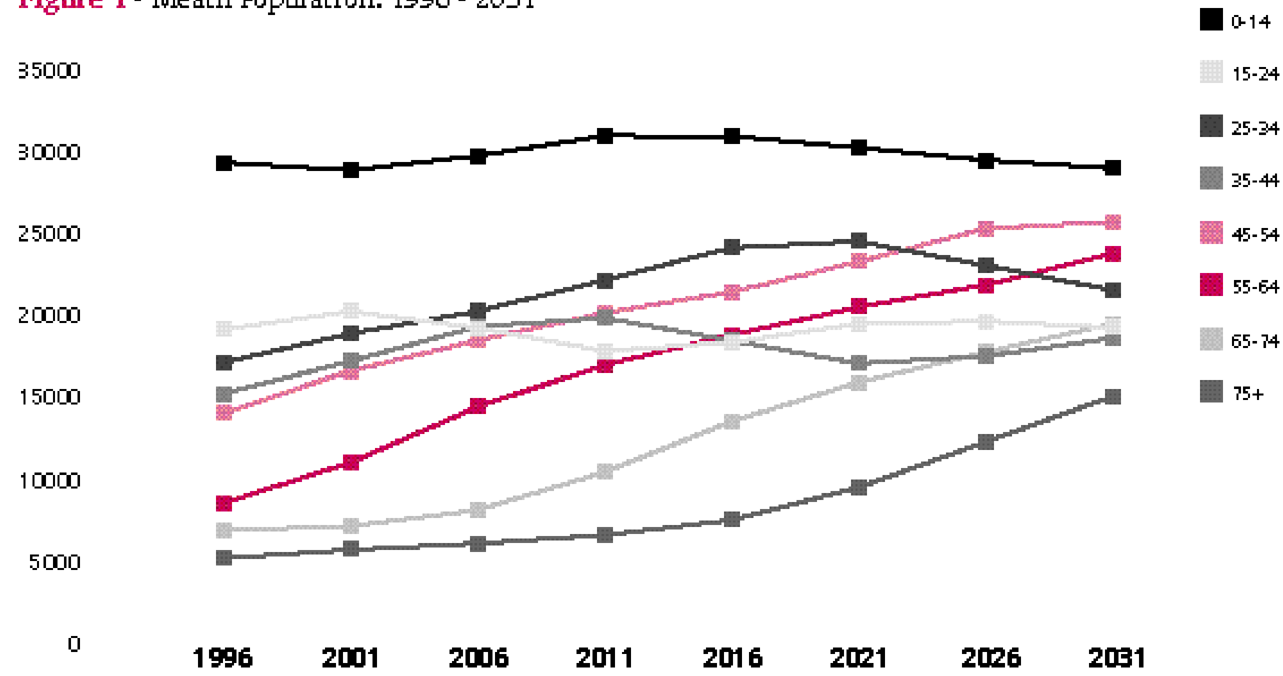

Figure 2 - Louth, Cavan, Monaghan Population: 1996 - 2031

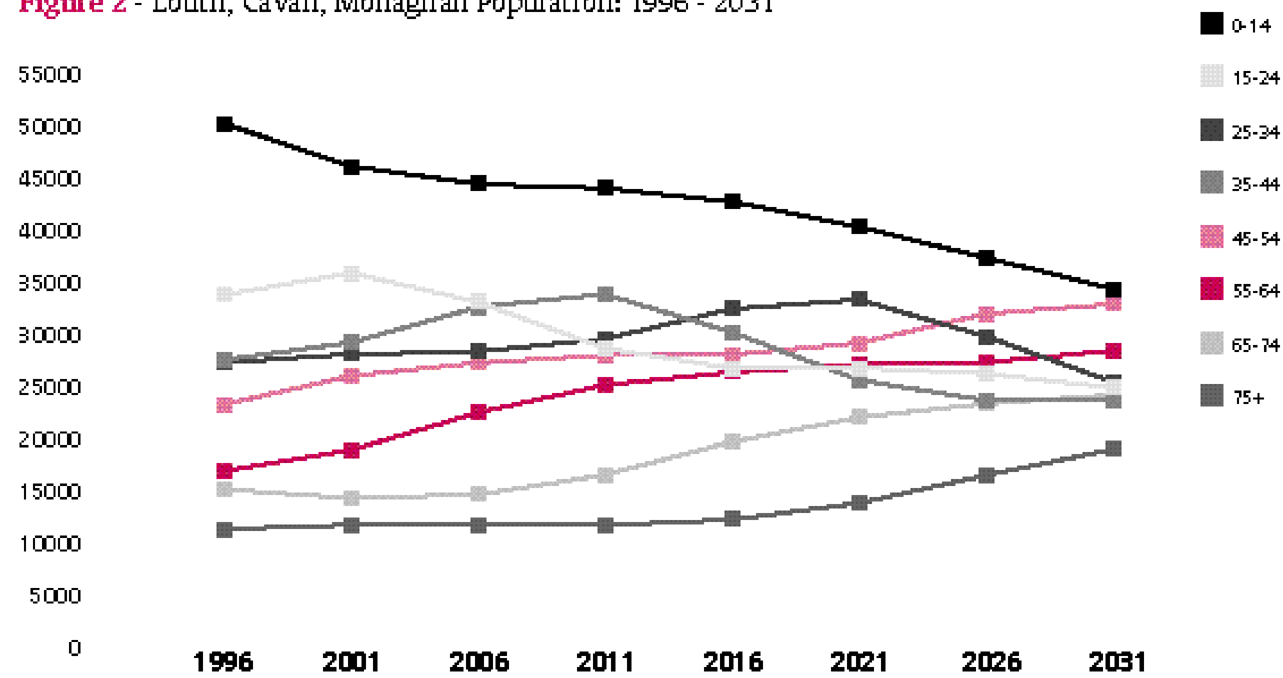

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Figure 3 - NEHB Population: 1996 - 2031

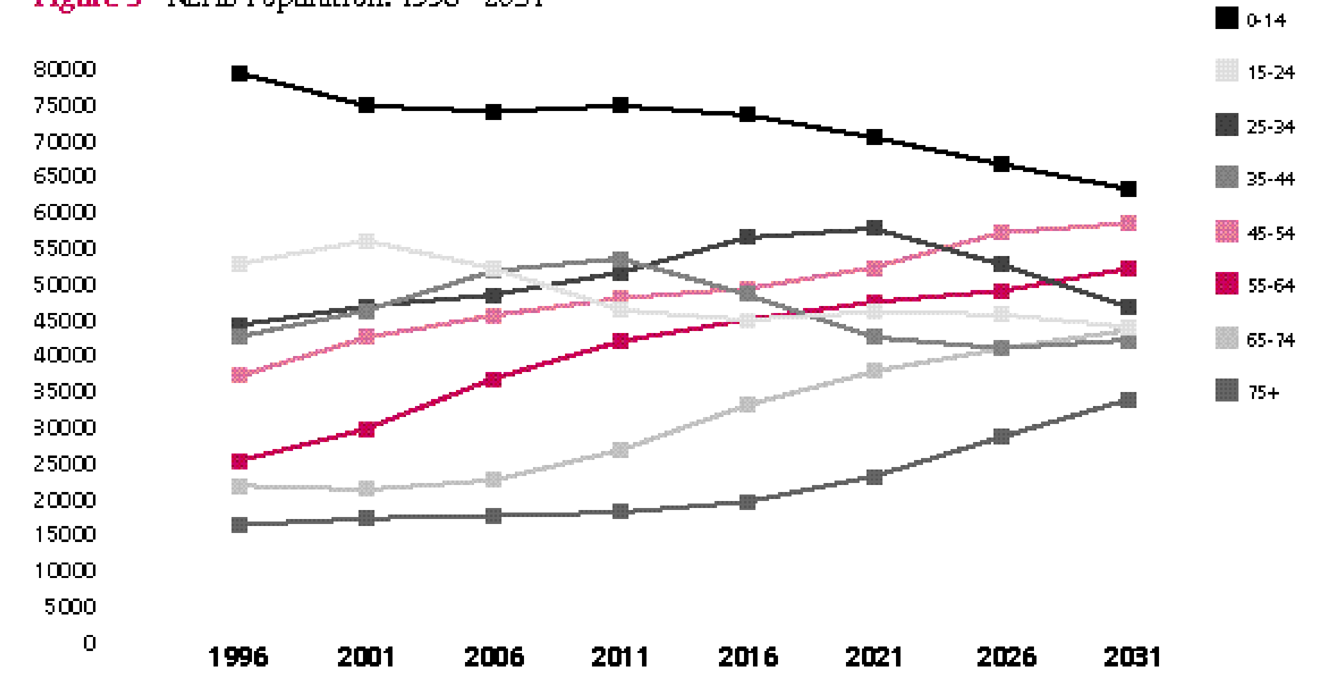
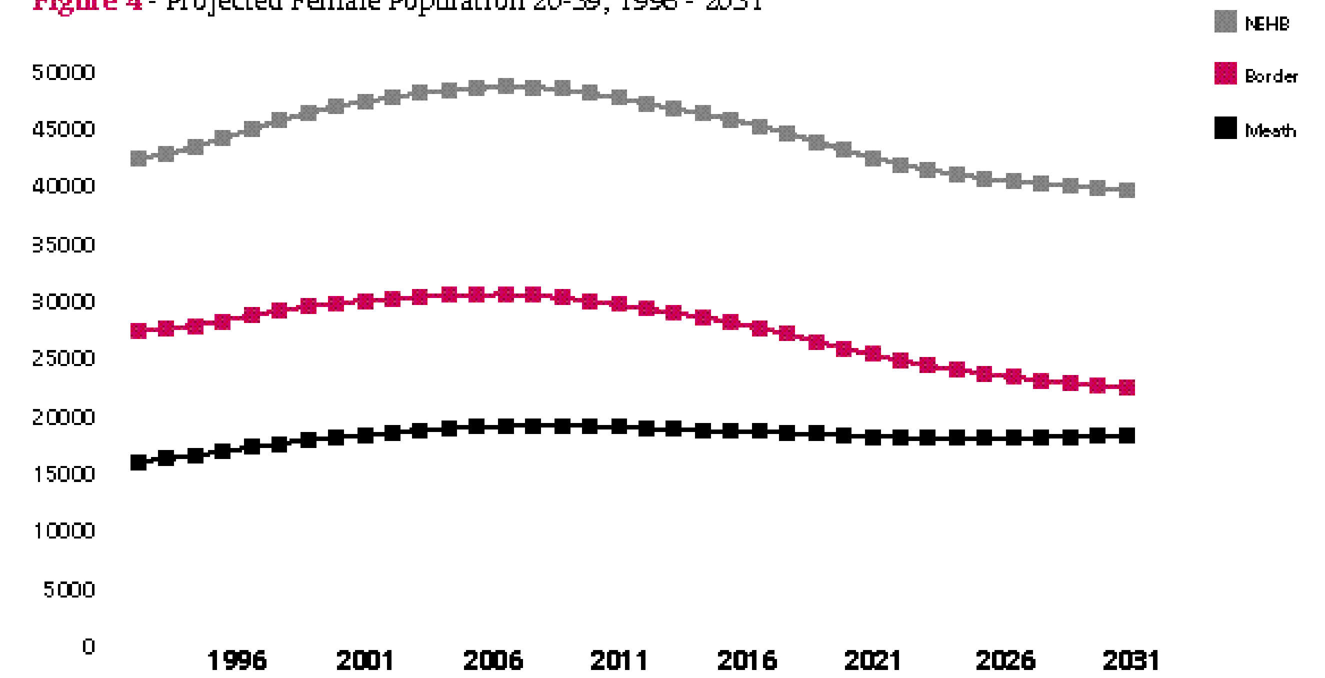


Figure 4 - Projected Female Population 20-39, 1996 - 2031



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Where do women from the North East give birth ?

In research that was carried out for the Condon Report, a quota sample of 511 women who had given birth in the previous 3 years were interviewed about their experiences in the hospital that they choose to give birth in. One of the questions asked which hospital they gave birth in and the table below outlines their response.

In Louth practically all births (81%) occur within the county. The Meath picture is somewhat different in that there is no maternity unit in the county. Most mothers from Meath go outside the region to Dublin maternity hospitals. Of those that stay in the north east most of them go to Our Lady of Lourdes. Cavan mothers are different again in that 84% of them stay locally, the rest are mostly distributed between Dublin maternity hospitals and Our Lady of Lourdes. Monaghan mothers show the most amount of movement with just over half of them staying locally in Monaghan, with the remainder going to other hospitals in the region or to hospitals classified as other, most of which are in Northern Ireland.

Looking at the hospitals, obviously Our Lady of Lourdes caters for the biggest number of mothers, followed by the Dublin maternity hospitals (most of their attendees are from Meath). Cavan General deals with its own community in the main with some mothers from Monaghan and Meath attending. Monaghan General would seem to only attract mothers from Monaghan, and at that it gets about 50% of them.

County of residence of mother- % attending maternity hospitals

Hospital attended	Louth (n=158)	Meath (n=189)	Cavan (n=87)	Monaghan (n=77)	**Total (n=511)**
Our Lady of Lourdes	45%	27%	4%	18%	**27%**
Louth County	36%	-	-	7%	**12%**
Cavan General	-	3%	84%	14%	**18%**
Monaghan General	-	1%	1%	51%	**8%**
Coombe, Dublin	1%	20%	2%	-	**8%**
Rotunda, Dublin	4%	16%	2%	3%	**8%**
Holles St, Dublin	4%	11%	2%	-	**5%**
Mount Carmel, Dublin	1%	3%	1%	-	**2%**
Mullingar General	1%	15%	2%	-	**6%**
Others	8%	5%	1%	8%	**6%**

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