Northern Ireland Assembly

Committee for Health

# OFFICIAL REPORT (Hansard)

## Severe Fetal Impairment Abortion (Amendment) Bill: Health and Social Care Trust Chief Executives

8 July 2021

# NORTHERN IRELAND ASSEMBLY

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## Severe Fetal Impairment Abortion (Amendment) Bill: Health and Social Care Trust Chief Executives

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**Members present for all or part of the proceedings:**
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

**Witnesses:**

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| Dr Cathy Jack | Belfast Health and Social Care Trust |
| Ms Jennifer Welsh | Northern Health and Social Care Trust |
| Ms Roisin Coulter | South Eastern Health and Social Care Trust |
| Mr Shane Devlin | Southern Health and Social Care Trust |

**The Chairperson (Mr Gildernew):** I welcome by phone Dr Cathy Jack, who is the chief executive of the Belfast Trust. We are also joined by Mr Shane Devlin, who is chief executive of the Southern Trust, and Ms Roisin Coulter, who is chief executive of the South Eastern Trust.

Clerk, do we have Jennifer Welsh, who is chief executive of the Northern Trust?

**The Committee Clerk:** We have been having problems getting Jennifer online. I will keep an eye on it and let you know when she comes online.

**The Chairperson (Mr Gildernew):** Thank you all very much. Tá fáilte romhaibh go dtí an Coiste Sláinte ar maidin seo. You are all welcome to this morning's Health Committee meeting. Thank you for coming along to provide us with your evidence and experience in relation to the matter. For the purposes of coordinating the session, I ask that, where a chief executive can substantively address a question from a member, he or she does so. Only if additional further information from one of the other chief executives is helpful, please indicate that, rather than having three answers to every question, if it is not necessary. I recognise that there are differences across the trust areas. It helps to use headsets and, members and witnesses, please remember to keep yourself on mute when you are not contributing to the meeting.

I will ask the chief executives to brief us in the order in which I introduced them. Dr Jack, will you give us your opening remarks?

**Dr Cathy Jack (Belfast Health and Social Care Trust):** Just to be helpful, we have together compiled an opening statement. Roisin Coulter, chief executive of the South Eastern Trust, will lead on that opening statement for us. I hope the Committee is content with that.

**The Chairperson (Mr Gildernew):** That is helpful. Thank you. Go ahead, Roisin.

**Ms Roisin Coulter (South Eastern Health and Social Care Trust):** Thank you, Chair and members, for the opportunity to attend and speak with you all this morning. I begin with a statement on behalf of all my colleagues, the chief executives of the five acute health and social care trusts in Northern Ireland, four of which, as you have mentioned, join us on the call today.

As members will appreciate, it is not the preserve of trust chief executives to comment on a private Member's Bill, namely, in this case, the Severe Fetal Abortion (Amendment) Bill. Informed opinion on the Bill must come from the clinical healthcare professionals who are the experts in that field. We know that the Committee has already taken evidence in that regard. Also, it is not appropriate for us to comment on policy on early medical abortion (EMA). That responsibility clearly rests with the Department of Health and the Northern Ireland Executive. We can, however, talk about the current provision of the early medical abortion service in Northern Ireland and the relatively unique challenges around that provision. We are happy to do so this morning.

As you are aware, the current service is not commissioned, which places significant demands on our staff and resources. In order to sustain the service and the support and counselling required for women, adequate funding is required and is imperative on a recurrent basis. If we add the pressures faced by staff and service users from groups fundamentally opposed to the provision of medical abortion in any form, the situation is sometimes far from satisfactory. Our position is clear: all patients and staff should be able to access any healthcare facility for any treatment free from harassment, intimidation or confrontation. We are relatively powerless to prevent peaceful protest, nor would we seek to do so. However, when protests cross the line and become intimidating or if staff and service users are being harassed, we are forced, as some trusts have experienced, to call the PSNI for assistance. This is an aspect of the service that is extremely challenging. While trusts strive to provide safe spaces for women using the service, that can sometimes be difficult.

Chair and members, thank you for listening. We are happy to take any questions that you might have.

**The Chairperson (Mr Gildernew):** Thank you, Roisin. Two questions from me, first of all. We have heard and seen evidence in relation to the difficulty of operating with uncertainty around provision and the lack of commissioning and the danger or risk that we may lose experts and consultants in fetal medicine as a result of that ongoing uncertainty. Is that something that concerns you? Are there concerns that it is a difficult area to operate in, given the current situation?

**Mr Shane Devlin (Southern Health and Social Care Trust):** It is fair to suggest that there is uncertainty with any service that is not fully commissioned and funded. We are continually providing resources to deliver this service. I stress our responsibility to provide safe healthcare services at the point of need. We are doing that and doing that well. Staff are choosing to work in this area, but, as it is not commissioned, you are correct, Chair: it places an uncertainty on the *[Inaudible owing to poor sound quality.]* That is a fair comment.

**The Chairperson (Mr Gildernew):** My second one is about an issue that has come up in numerous sessions, namely the support and, in some cases, the lack of support for women during pregnancy when there is a need to terminate a pregnancy or to carry a pregnancy to term and beyond. Are services adequate? What services are particularly in need of resourcing or development in supporting women with pregnancies?

**Ms Coulter:** The service in the South Eastern Trust has been operational from June 2020. We have a small but dedicated and committed team providing that service for women. As you know, it is provided in partnership with a charity. The charity is excellent in providing very early counselling, support, triage and onward referral for all individual women coming through to the health and social care trusts. Whenever we meet our team and ask them what they need to provide the service to the highest possible standards, they say that we need dedicated staff allocated to providing the early medical abortion service, dedicated time and specialist training. Specialist training has been provided to date, but there is a need for ongoing training, not only in relation to clinical practice but regarding counselling pre- and post-early medical abortion and ongoing pregnancy. Both the charity and the trusts have a role in counselling and support for women. It is not only counselling. This is a wrap-

around service. It needs to be provided by dedicated medical practitioners with clinical nursing support staff, but there is a need for counselling and, sometimes, social work support, which is important.

We carried out a small review of the women who have attended our service, just to ask for feedback. All of them said that they had had a positive experience from the service and felt supported despite it sometimes being a difficult time, as you can understand, when women are nervous and apprehensive. They are overwhelmingly grateful for a service that, they feel, is needed. Hopefully, that is reassuring.

**The Chairperson (Mr Gildernew):** OK. Thank you.

**Mrs Cameron:** I thank the panel from the trusts. I appreciate your time on what is and continues to be a difficult issue for Northern Ireland. I have a couple of questions. The first one is whether you, as trusts, believe that your staff would benefit from an amendment to the law on abortion in cases of severe fetal impairment, given the debate over unclear terms such as "substantial risk" and "impairment".

**Dr Jack:** Pam, my staff see their role as similar to mine: fundamentally, that is to provide safe, lawful services that are free at the point of need to those who need them in a way that is non-judgemental, supportive and compassionate. It is not our job to judge people and their choices or to become involved in matters of policy, politics or party opinion: in fact, the GMC code and many of the other professional codes make it clear that we may talk about our personal beliefs only if a patient asks us directly about them or indicates that they would welcome such a discussion. We must not impose our beliefs and values on patients or cause distress by inappropriate or inconsiderate expressions of them. I need to be clear: it is not my role nor that of my staff to judge anyone who turns up at a point of need and needs a service. We will offer that service free at the point of care and safely. That is our job.

**Mrs Cameron:** Thank you for that, Cathy. I will move on to my next questions. They are in and around the Northern Ireland Human Rights Commission's recent recommendations on the operation of conscientious objection provisions for medical professions. It suggested that those are too broad and unduly impact on services. I have some questions about that. As trusts, how do you respond to that? What processes are in place to constructively facilitate exemptions for staff with deeply held beliefs? Does conscientious objection extend to ancillary services? Finally, how many staff in each trust have availed themselves of conscientious objection provisions?

**Mr Devlin:** To begin, I can give a view from the Southern Trust, if that would be helpful.

**The Chairperson (Mr Gildernew):** Yes, go ahead.

**Mr Devlin:** We absolutely facilitate individuals — all staff — who would be involved in the provision, in this case, of early medical abortion to enable them to be conscientious objectors. Our services are delivered, in this case, in our integrated women's directorate, so a record is kept at a local level of individuals who choose not to participate in services for reasons of conscientious objection. That is available to all. I do not have a single standard record for the trust, so I cannot answer your question on that, Pam. However, I am more than happy to come back to the Committee if that is OK with you. It is clear that we have local systems to allow people to raise that and to avail themselves of that. To date, that has not had a detrimental impact on my ability to deliver the service. However, we are talking about a relatively small early medical abortion service run by a relatively small number of professionals. Therefore, that has not had a major impact on the delivery of early medical abortion, but the processes are there should people wish to avail themselves of them.

**Ms Coulter:** Can I add to that?

**The Chairperson (Mr Gildernew):** Yes. Go ahead, Roisin. I will check with Dr Jack after that as well.

**Ms Coulter:** Thank you, Chair.

Pam, the South Eastern Trust is similar. I reassure you that we absolutely have a process in place for conscientious objection by all staff, and we follow the guidance produced by the royal college and the Royal College of Nursing (RCN) on that. A small number of staff have expressed conscientious objection, and that is absolutely facilitated. They work in the service and are content to support women pre- and post-abortion. We are content with that. It is not having any impact, as Shane said, at this

moment in time, but, if the service were to grow dramatically, we would have to keep it under close monitoring.

**The Chairperson (Mr Gildernew):** Cathy, do you have anything to say about your position on conscientious objectors and the impact on the service?

**Dr Jack:** There is no impact on the service. We have a small number of conscientious objectors who work in maternity hospitals. None work in the early medical abortion service. As you know, that service was set up very fast during COVID when it became a legal entity and we needed to do something for women in need who could not access services elsewhere. People chose to come and work in that service. We did not ask people who had any significant conscientious objection. In maternity services, there are a small number of them. We are very much aware of them, and we work with them and support them, because everybody is entitled to their view. The role is clear: if you feel uncomfortable, we pass it over to someone else who is comfortable providing that service, and no woman is left in need.

**Mrs Cameron:** Chair, can I come back in there?

**The Chairperson (Mr Gildernew):** Go ahead, Pam.

**Mrs Cameron:** Thank you.

**The Chairperson (Mr Gildernew):** Briefly, please.

**Mrs Cameron:** Thank you all for your responses. I want to go back to the first part of that question, which was in and around the Human Rights Commission commentary that this was too broad and would unduly impact on services. Would it be fair to say that what is in place for conscientious objection is not too broad and does not unduly impact on services?

**Mr Devlin:** Pam, I can say at the moment that it has not unduly impacted; that is not the same as saying that it might not do so into the future. At the moment, I can evidence that it has not had undue impact.

**Dr Jack:** Likewise for the Belfast Trust.

**Mrs Cameron:** Thank you, Cathy.

**Ms Bradshaw:** Thank you, chief executives, for being here this morning. My first question is about your positions as chief executives. Are you assured that the clinical governance framework is in place in each of your trusts to ensure that you adhere to the regulations around the provision for two healthcare workers, for example, to be involved in the decision-making around clinical governance?

**Dr Jack:** From a Belfast Trust point of view, I have been assured, I have seen the data and I know our governance processes. I am content that we offer a safe system for those who need that service.

**Ms Bradshaw:** Thank you. I see some nodding heads there.

**Mr Devlin:** From a Southern Trust perspective, I concur, Paula.

**Ms Bradshaw:** Thank you. The next question is about screening. I cannot remember which witness it was, but there was an indication that some of the screening that we perform at the 20-week scan is performed in GB at 12 weeks and that can pick up some chromosomal abnormalities and other issues at an earlier stage. Do you think that we should introduce that in Northern Ireland?

**Dr Jack:** I am happy to take that, colleagues. Earlier routine screening is not available for fetal abnormality in Northern Ireland. It is not commissioned and therefore not routinely offered. It would be helpful.

**Ms Bradshaw:** That is great. Thank you.

The next question is about genetic testing, and I suppose that it follows on from the last question about mothers who have multiple pregnancies where the same issues keep arising. Do you think that there is enough capacity in our trusts to work with women around testing post pregnancy to see whether there is anything that can be done to support them with future pregnancies?

**Dr Jack:** I will take that, because it is probably for the regional service. We offer that service in Belfast. Our consultant geneticists, along with our neonatology service, are involved in counselling when issues like that arise. If the pregnancy proceeds, we also, at times, involve the bereavement midwife. So we offer support and counselling. There may be a need to grow that service as other services are commissioned. I will take that back and get a bit more detail about what I offer and whether or not there is a need to expand that service, but the service is available.

**Ms Bradshaw:** Thank you. Finally, I just want to thank all the trusts for stepping up when there have not been commissioned services. I know that a lot of women are extremely grateful that they do not have to travel to England. My one criticism is that not enough information is available on your trust websites. We know that women use Google and end up finding places like Stanton that do not necessarily provide the support that they are looking for at that time. Can you look at that going forward, so that women facing crisis pregnancies can have timely and accurate information about referral to the central access point and other services in your trusts that can support them at that critical time?

**Mr Devlin:** I will certainly review our website, Paula. At the end of the day, any service that we provide must be accessible, and our websites are a very important way of making those services accessible. If the comments coming back to you are that they have not felt accessible because of what is on the website, I will review that to see what should be on the website.

**Ms Coulter:** We are also happy to review that. We have the referral to the central access point through the charity on our website. That is the way we have gone. I suppose that there is a need to provide clear information to women about how to access the service, but that needs to be balanced against sensitivity and the need for confidentiality and privacy. We are always mindful of that as well. As with the others, we are happy to review that.

**Ms Bradshaw:** Thank you.

**Dr Jack:** Paula, that is really helpful feedback. Thank you very much for that. I will make sure that it is reviewed to see whether there is anything more that we need to do.

**Ms Bradshaw:** That is wonderful. Thank you very much, everybody.

**The Chairperson (Mr Gildernew):** There is a wee bit of feedback on your sound, Cathy, but we can hear you and are following the sense of it. I am not sure whether there is anything you can do to reduce the feedback. In the meantime, I will go to Gerry Carroll.

**Mr Carroll:** My camera is not working for some reason, but hopefully you can all hear me. Thanks to the chief executives.

**The Chairperson (Mr Gildernew):** We see you, Gerry.

**Mr Carroll:** That is good to know, thanks.

My first comment is to concur with the Chair and others about the protests at healthcare facilities and facilities that provide information or termination procedures. Those protests are obviously abhorrent and very disturbing and concerning. The correspondence that we received from Dr Jack's team detailing the security personnel that have to be put in place for women who are getting access to those services is very concerning. I just wanted to comment on that.

Cathy, you said that you are not going to comment on policy or give your opinion on the Bill. That is fair enough. I am concerned about the impact that the Bill would have on women if it were implemented. Maybe you can speak to that. We have heard that the Bill would essentially prevent a handful of terminations taking place but that, in the long run, it could lead to more taking place because the 20-week limit might force women to make decisions more quickly, before they have all the information or the support in place. I do not want to know if you agree or disagree with the Bill, but,

if it was implemented, what would be the impact on what are, I suppose, already limited services? Can anybody comment on that?

**Dr Jack:** Chair, I can take the point about the protesters.

**The Chairperson (Mr Gildernew):** Go ahead, Cathy.

**Dr Jack:** Gerry, that concerns us. My staff recognise that peaceful protest is an absolute right and should be allowed, but it is not comfortable for individuals to have to be concerned or worried about accessing their workplace or the welfare of patients. Since we started that service, I have had two incident reports about the protesters, and I know that many patients report that they have been worried in what is an already anxious and stressful situation for them. Fundamentally, no one should feel intimidated by any protests.

We have put on extra security. There is a security presence at the front door. We have put special glass in the windows, are putting special glass into the front door and are installing an outside security camera. I thank the PSNI, which has been very helpful on occasions when its support was necessary. Did I want to do that? No, I would have preferred to spend that money differently and for the betterment of the experience of patients and service users, but it has been a necessity. I want to put that caveat out there, and there have been two incident reports about the protesters that we have met outside our EMA service.

**Mr Devlin:** I do not believe that I am qualified to answer your other question, Gerry. We would have to look to clinicians to see what the impact would be and whether it would drive demand before 20 weeks etc. I know that, at the beginning, we said that we would not comment, but I just do not feel that I am even qualified to comment on that. It would be pointless for me to do that. Apologies. Clearly, clinicians are feeding into the consultation, and I am sure that they will be able to give a view on that.

**Mr Carroll:** Thanks. That is the indication that they gave. My understanding of the Committee presentation was that the Bill would potentially increase the number of terminations before 20 weeks. The other point is that there are obviously people going through difficult pregnancies who would be traumatised by the focus of some aspects of the Bill.

Finally, will you comment on the fact that, during the pandemic, when people were told to stay at home and not travel, almost 400 women were forced to travel for abortion services because there was a lack of services or limited services after 10 weeks? Almost 400 women were forced to travel in the last year. That is troubling and difficult at any time and for any aspect of healthcare, but with terminations it can be more difficult for women. Does anyone want to comment on that lack of provision?

**Dr Jack:** In Belfast, we recognise that the EMA service has a current limit of nine weeks and six days and that there is a gap between 10 and 12 weeks. We are actively looking at how we could provide that. It would have to be done in a hospital and there would be cost pressures, but I assure you that we are actively looking at how we can do that, Gerry.

**Mr Carroll:** OK. Thank you.

**The Chairperson (Mr Gildernew):** OK. I see that we have been joined by Jennifer Welsh, the chief executive of the Northern Trust. Jennifer, you are very welcome to the meeting.

I will go back to members' questions. Órlaithí, lean ar aghaidh le do cheist, le do thoil.

**Ms Flynn:** Go raibh maith agat, Colm. Thank you very much to the panel.

In the previous session with the Minister, we discussed the commissioning of abortion services, and we had written to the Minister about that. The Committee had serious concerns about the protests that were taking place at some clinics.

In the Minister's response on 16 June, he confirmed that the Department of Health is resuming work to develop the service specification for the commissioning of abortion services. My first question is whether you, as chief executives of trusts, have any input into that process?

My second question concerns some of the feedback that we got from a previous briefing, when we heard from clinicians on the issue. One of the big issues that came up was psychological supports for women going through those processes. There are concerns that there seems to be postcode lottery, depending on which trust you fall under. Psychological support for maternity cases is provided only by the Belfast Trust. When the services are commissioned, what are your opinions on the need to build on those important mental health supports that many women and families clearly need when they go through these difficult periods?

**The Chairperson (Mr Gildernew):** Thank you. Who wants to lead on that?

**Ms Coulter:** I can start. There have been requests for nominations from all trusts to sit on the regional group to input into the development of the commissioning specification. We will be actively involved in that and working with the Health and Social Care Board (HSCB).

As to your question about psychological support, across the trusts, women will need different levels of psychological support. In the South Eastern Trust, we will provide a counselling service in the early medical abortion service and then, as Cathy mentioned, there is the bereavement midwifery service as well. However, if a further, or higher, level of psychological support is needed, then it would be accessed through the Belfast Trust.

**The Chairperson (Mr Gildernew):** Do any other witnesses wish to contribute?

**Mr Devlin:** It is an important point. Good commissioning commissions a complete service. The aim of commissioning is to meet needs. My job, as a provider, is to respond to that commissioning intention and be able to deliver service. It is very important that, when we look at the commissioning framework, or what is going to be in it, it should not be just about one act but should be a complete pathway for a woman through this.

It is important that we strongly influence the commissioning process to make sure that the service commissioned is a genuine end-to end service that looks at psychological as well as physiological challenges of that complete pathway. All our trusts are up for making sure that a comprehensive commissioning plan is put in place to get the right service for our patients.

**Ms Flynn:** Thank you, Shane and Roisin.

**Dr Jack:** Shane has absolutely made that clear. Any commissioned service needs to include the entirety of a woman's need in that situation and that of the wider family. It is absolutely essential that psychology services are included in the commissioning, when it happens.

**Ms Jennifer Welsh (Northern Health and Social Care Trust):** Chair and Órlaithí, just to back that up, the services that we are providing are interim services and, by their very nature, they are limited in what we can provide. I strongly support that we could do much better with a fully, properly commissioned, service.

**The Chairperson (Mr Gildernew):** When did the process of engagement in developing the service with you start? Jennifer, did you indicate there? Go ahead, Roisin.

**Ms Coulter:** I was just checking. At the end of May we had the request from the Health and Social Care Board to start the work on the specification.

**The Chairperson (Mr Gildernew):** Thank you. I will go Jonathan Buckley and then to Carál Ní Chuilín. Jonathan, go ahead with your question, please.

**Mr Buckley:** Thank you very much for your presentation. When I begin my contribution to these sessions, I always say that, primarily, healthcare resources should focus on saving life not taking it. I am clear on that.

On a number of occasions, it has been raised that people have the right to protest against abortion services respectfully and peacefully. There have been allegations of staff and patients being harassed, and, of course, where criminal offences have taken place, those should be reported to the PSNI. However, protest and opposition are protected under the European Convention on Human Rights and, in and of themselves, are not illegal. I will ask a couple of questions leading on from that.

Is it fair to say that the majority of those protesting against the operation of abortion services do so peacefully? On what grounds has the PSNI had cause to physically remove individuals from trust sites in the incidents that you outlined?

**Dr Jack:** We have been running the service in the centre of Belfast since the end of April 2020, and I told you that there have been only two incident reports. Jonathan, that makes it clear that the vast majority of the protests have been peaceful and respectful. We have no problem with that, and I started my answer to the question about the protesters by saying that. However, it is right and proper to point out that there have been two incident reports. They are small in number when we consider that the service has been running for well over a year. Equally, however, it is important that we recognise that I have had to put resource into improving security for those who use the service and those who work there.

**Mr Buckley:** OK. I suppose that it is good to put that in context. Some have attempted to use what you described as a minority of disturbances as a widespread issue and, in my opinion, have demonised the right to legitimate protest against a service that, they feel, is taking life. That is my first point.

Secondly, the trusts have been keen to stress that the resourcing of early medical abortion services has not led to a reduction in financial or staff support for other key or front-line services. That begs the question of where those staff and budget lines came from. Was there a recruitment process? How would the trusts approach any full commissioning of services from a resource standpoint?

**Ms Welsh:** Jonathan, I will go back to your first point about protests. I am conscious that colleagues covered elements for their areas. We have reported 15 incidents of protests in the organisation: one in February; one in March; two in April; three in May; and eight in June. Therefore, the situation has escalated. I agree with you and strongly support the right to peaceful protest, and the majority of the weekly protests have been peaceful at the service provided in the Northern Trust area. I advise that we moved the service again yesterday, but, up until then, it was becoming extremely challenging for the staff providing the service as well as for those accessing it.

The nature of the incidents that we reported internally included things such as protesters outside the clinic intimidating staff and clients attending the service and across various services; incidents of people using graphic images and language that was upsetting for individuals accessing the service; and incidents of protesters taking video and photographs of service users without permission. On occasion, we have had to seek the support of the PSNI. We have also had incidents of a member of the public spray-painting a sign and spray-painting a protester. It has been extremely challenging.

I agree with and strongly support the right to peaceful protest without disruption. Like Cathy, we have had to take some extraordinary measures to support staff and individuals accessing the service, and we have moved it several times. We have moved it, yet again, to another location, which I will not disclose; I am that sure you will understand why. The service yesterday took place peacefully and without disruption for any of the staff, those needing to access the service or, indeed, those in neighbouring services. We hope that we can continue with that.

In relation to the funding, as I mentioned, it is an interim service; it is not the full service that ideally should be provided. Therefore, it is limited. We are doing this on a non-recurrent funded basis and with the aid of locum staff, so I assure you that it is not impacting on any of the other services that we are fully commissioned to provide.

We have indicted to the Health and Social Care Board and the Department that this is not a long-term, sustainable solution. The answer is in a properly commissioned service to ensure sustainability. Work is ongoing with the Department of Health and the Health and Social Care Board on that service specification.

**The Chairperson (Mr Gildernew):** Shane, I think you were looking in on the first question; and if you have anything on the second question.

**Mr Devlin:** My response is very similar to Jennifer's. Patients of other services have written to me about feeling intimidated as they walked through the protest. We, too, had to move the service on more than one occasion. In fact, we now provide our service in two locations — neither is the location that we started with — because of the intimidation and fear that our staff felt.

I must agree with Jennifer: we have to balance that with the right to peaceful protest. It is important in our society that people are entitled to protest peacefully, but I can reflect to the Committee how some people have felt about verbal protests and images etc as they tried to make their way into services. I stress that we provide this service in facilities that provide many services. I have been engaged with a number of mental health clients who have felt very disturbed by the process. We must uphold the right to peaceful protest — there is no question about that — but it is a balancing act, and I have staff and patients on both sides who are feeling concerned.

With regard to the point that Jennifer made about funding, we are in exactly the same position. This is locum, short-term and non-recurrent funding. For this to be sustainable, without having an impact on other services, Jonathan, you are correct, it would need to be commissioned. Any good commissioning process would look at the resources required to provide this service in a sustainable way.

**Ms Ní Chuilín:** Thank you very much for your presentation. A lot of questions have been asked, and I appreciate your responses. I want to repeat what NIACT, RCM and the royal colleges told the Committee. First of all, these are professional people offering professional services in a sensitive and compassionate way. That needs to be accepted and respected.

They recorded their concern, and, indeed, alarm, on some occasions, about the way in which women were accessing services. As you all pointed out, the balance between the right to protest and what are considered acceptable protests or acceptable ways to protest has not been achieved. The graphic images being thrust into people's faces, staff having to accompany patients to their vehicles, and staff then having to be accompanied by security back to the health and social care setting are not peaceful. Equally, it is not peaceful when people trying to access healthcare, not EMA but another form of healthcare, were subject to verbal abuse and had graphic images put in front of them. With all that said, my concerns are about the commissioning aspects. I appreciate what you are saying and what you have done. We have concerns primarily about the Western Trust as well and the fact that there has been a suspension from April. I want to find out what is happening there.

We have talked about commissioning, the dissolution of the Health and Social Care Board, and the role of commissioning there. Can you respond to the point that it is not just EMA services but the entire wrap-around, pre- and post-services that need to be commissioned and implemented, including psychological supports?

My last question is about the charity in the middle of all this, which is the central access point. If its funding, for example, is not continued and, as you have outlined, measures have been, taken to relocate services on several occasions because of what people have had to endure, together with your reluctance to give additional information online to protect everyone, how can we ensure that that access point is supported so that people who need the services most get them? The last thing we need is that when people go online they are referred to a so-called health and social care setting about abortion but it is not: it is not about early medical abortions — far from it. Some of the things that we have heard are disturbing.

I will leave it at that, Chairperson. I put my gratitude on the record.

**The Chairperson (Mr Gildernew):** Thank you, Carál. I will check in with Cathy Jack first. She is at a bit of a disadvantage because she cannot indicate. I will take indications from the other panel members, but I will just check whether Cathy wants to pick up on some of those points.

**Dr Jack:** Carál has made a number of really important points. I see this as an entire pathway. Carál will know that, for other reasons, I believe that psychology is essential in any care pathway, so I want to see it fully commissioned. These are not regional services; they are local services provided on a population basis. So, when the board is going through its changes, I would see this being commissioned locally, although we need to make sure that, regionally, it is equitable and that there are no differences across the trusts so that there is not a postcode lottery. It will be delivered locally, but the specification and the resources must be there.

I would also like to reiterate that the facilities that provide this service also provide many other services and are accessed by many service users, not just those who find themselves in early pregnancy and who are struggling with what that may entail for them. The charity's work has been a good example of a partnership approach. It offers open and holistic options for women to consider and discuss. We are

not offering a one-stop shop. We discuss it with them and give them time to reflect. We make sure that all the options are there so that they have fully informed choices.

Any reduction in funding to that central charity would really concern me. Nevertheless, my role as chief executive is to provide a service that is legal and safe where there is a point of need. I will endeavour to do that. The charity's work with the trusts across the region has been an excellent example of partnership, and I would like to see that continue.

**Ms Welsh:** I strongly support what Cathy was saying on all those points. I particularly want to pick up on the charity, Informing Choices Northern Ireland.

There are huge benefits in having a centralised access point across Northern Ireland and linking to all of the trusts. It ensures consistency in approach and the standardisation of information, which we talked about. If that were withdrawn for any reason, we would have to look at how we could develop that on a local basis, but it is stronger as it is from that centralised point and having all the trusts linking in to it. I am strongly supportive of that service continuing and trying to support it as best we can.

**Ms Coulter:** I was going to make exactly the same point as Jennifer. We in the South Eastern Trust feel that the central access point is a very important part of the service. It is about recognising that referrals come from right across Northern Ireland and from not only the individual women but a range of healthcare professionals and GPs. That initial point of contact is so important. We will then all work together to ensure that a consistent service of an equal standard is provided right across the region. That is very important. It would cause added pressure if individual trusts were the first point of contact and the referral point. It is much better to do it through Informing Choices or something similar.

**Ms Hunter:** Thank you to the panel for being here this afternoon. I will comment on the protests outside clinics. No woman, regardless of her decision, should have to endure the harassment and intimidation that we have seen. I am mindful of some of the recent incidents that Jennifer touched on in my constituency in the wider Coleraine area. There is an evident need for buffer or access zones. Intimidation aside, there is a real concern for patient confidentiality. Although we wholeheartedly respect peaceful protest, those clinics — those medical facilities — are an entirely inappropriate place for protests.

I have two questions. Jennifer, it might be you whom they are directed to, just on the basis of the Northern Trust. It was touched on previously, but will you elaborate on what steps are being taken on buffer zones and what conversations you are having with the Department on them? Due to the nature of the protests, do you foresee the service being moved?

**Ms Welsh:** Thank you, Cara. I have covered a little bit of that. We were concerned about the service in the previous location, and we made a decision to move it yet again. It moved yesterday. It is in an alternative location where we can better provide for a buffer zone. It took place yesterday peacefully and without incident. The circumstances are much better for all the staff involved and for the individuals who access the clinic, not to mention neighbouring services and other people who are simply in the area. We are hopeful that that will remain the case. I will not disclose the location.

It is challenging to provide buffer zones because of the nature of healthcare facilities; they are, by their very nature, public buildings. We have engaged with PSNI on how we can support people to provide a peaceful process and to be able to access the services safely and effectively. We believe that the solution that we have at the moment will work, but we will keep a very close eye on it. I hope that we do not have to move it again. As I said, we are engaging with PSNI to make sure that where we have chosen remains a safe and appropriate place.

**Ms Hunter:** That is reassuring, Jennifer. Thank you very much.

**The Chairperson (Mr Gildernew):** Do any other members of the panel want to come in on any of that or on anything additional to that question? No. OK. Thank you. The psychological supports, including counselling and signposting, have been fairly well dealt with. That is hugely important. I am concerned about what we are hearing. I respect people's right to protest freely, but when we hear about services being moved, intimidation, and security guards having to be put on to protect women, and others requiring medical care, it creates a hugely worrying picture. It is almost creating a situation in which services are being driven underground in a clandestine way. That is far from satisfactory. The Committee will want to give that further thought in its considerations this morning.

I thank each of the chief executives for attending. Given the situation in the Western Trust, particularly its suspension of service, it is regrettable that its representative has not been able to attend. Thank you for assisting the Committee in its considerations. I wish each of you all the best in what, I know, is and has been a horrendously difficult time due to COVID, and I acknowledge the work and effort of you and your entire staff in dealing with it. I acknowledge that we are not yet out of the woods with regard to pressures generally or, in particular, COVID and how they interact with each other. The Committee understands the huge difficulties that you face and the balancing acts that you are trying to perform due to hospitals being already at full and overfull capacity and the looming vista of further cases coming through the system. The Committee acknowledges your work and will do all we can to play our part in supporting you in the delivery of the crucial service that you provide to our community.

Thank you for that and for appearing. We have slipped into the afternoon, so we have crossed the yardarm. We appreciate your attendance. Go raibh maith agaibh.