Chairperson, Deputies and Senators,

My colleagues at the Institute (of Obstetricians and Gynaecology at the Royal College of Physicians of Ireland) welcome the opportunity to once again discuss the implementation of the National Maternity Strategy 2016 with the Joint Committee on Health. In particular, we are grateful for the opportunity to highlight the current situation with regard to national access to routine obstetric ultrasound.

As you will be aware from our previous appearance before this Committee, there are many fundamental inequities in the provision of women's health care in Ireland in 2017. Recently, several high profile and very tragic cases have focused national media attention on the lack of access to standardised obstetric ultrasound.

Internationally, the widely accepted minimal schedule for antenatal ultrasound comprises of two examinations; a dating ultrasound in the late first trimester, followed by a fetal anomaly scan, usually performed between 19-22 weeks' gestation [1,2,3]. The main purpose of the anomaly scan is to screen for structural fetal abnormalities to facilitate prenatal diagnosis of a wide range of conditions. This minimal ultrasound schedule is available throughout the overwhelming majority of countries in the OECD, including the UK, Canada, France, Australia, Germany and New Zealand, and uptake is close to 100%. In line with this, the National Maternity Strategy, has also stipulated that '*all women must have equal access to standardised ultrasound services, to accurately date the pregnancy, to assess the fetus for ultrasound diagnosable anomalies as part of a planned Prenatal Fetal Diagnostic Service, and for other indications if deemed necessary during the antenatal period*.'

Without nationwide access to anomaly scans, we continue to provide inadequate or inappropriate care to mothers and babies, which impacts upon clinical outcomes, sometimes with devastating consequences. For example, babies with undiagnosed structural anomalies such as cardiac defects will be born outside centres of paediatric surgery and will require emergency ex-utero transfer to Dublin immediately after birth. For some babies, this will significantly decrease their chance of survival. In other cases, an absence of ultrasound means that the opportunity of in-utero fetal therapy will be missed and babies will die of potentially treatable conditions. A lack of ultrasound also has detrimental effects on maternal health. Women will continue to have unnecessary caesarean sections and other interventions for infants who

cannot survive. Families will continue to be deprived of prenatal palliative care, to enable them to prepare for their baby's death. Obstetricians will continue to deal with unexpectedly bad outcomes at sometimes extremely complicated deliveries. We are expected to explain to parents how a major anomaly, normally clearly visible on routine ultrasound, was not diagnosed and to assist parents in dealing with the aftermath of a traumatic delivery and either unexpected bereavement or unanticipated illness or disability.

During the previous meeting of this Committee, Members asked questions regarding the availability of ultrasound across this country. My colleagues have previously published data on this topic in 2007 [4] and 2012 [5]. In the last two weeks, we have repeated this exercise. We conducted a nationwide survey of all 19 maternity units in Ireland (combined number of births in 2016=65,000). Anomaly scanning is offered universally to all women in seven units (37%), selectively to some women in seven units (37%) and not at all in the remaining five units (26%). **Overall in 2016, 23,300 (36%) of women attending antenatal services in Ireland did not receive a fetal anomaly ultrasound** (see appendix).

The reasons underlying this gross inequality are neither complex nor insurmountable. The fundamental issue underpinning why some hospitals can provide this scan and others cannot is one of governance. In maternity hospitals without ring-fenced budgets and robust independent governance, women's healthcare competes with other clinical priorities and international experience demonstrates that it is always the first to be cut. It is no coincidence that the maternity hospitals under the auspices of a single individual with both clinical and executive authority are able to provide universal routine anomaly scanning.

This situation with regard to fetal anomaly scanning has remained virtually unchanged for the last decade and is one of several critical limitations on the care that we can provide to women and babies, which continues to raises serious questions regarding the inequity of women's healthcare provision in Ireland in 2017. The single most important intervention, recommended in the Maternity Strategy, which would address this and other limitations in our service and immeasurably improve the care we can offer, would be to immediately appoint and empower Clinical Directors with full clinical and executive authority for maternity services nationally.

Once again, we welcome the National Maternity Strategy and sincerely hope that it is adequately resourced and implemented in full and without further delay. Irish women and their families deserve it.

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Louise Kenny is Professor of Obstetrics at University College Cork, a Consultant Obstetrician and Gynaecologist at Cork University Maternity Hospital and the founding Director of the Science Foundation Ireland (SFI) funded Irish Centre for Fetal and Neonatal Translational Research (INFANT). Professor Kenny trained in the NHS in the UK, where she also worked as a Consultant before moving to Ireland 10 years ago. She has raised over €30 million in peer reviewed research grants and she has published over 200 original scientific research papers largely related to adverse pregnancy outcome.