DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Déardaoin, 16 Feabhra 2017

Thursday, 16 February 2017

The Joint Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Bernard J. Durkan,	Senator Colm Burke.
Deputy Kate O'Connell,	
Deputy Margaret Murphy O'Mahony,	
Deputy Louise O'Reilly,	

DEPUTY MICHAEL HARTY IN THE CHAIR.

The joint committee met in private session until 9.30 a.m.

National Maternity Strategy: Discussion (Resumed)

Chairman: The purpose of this morning's meeting is to engage with representatives from the Institute of Obstetricians and Gynaecologists and the Association for Improvements in the Maternity Services, AIMS, Ireland, in regard to the national maternity strategy 2016-2026. This meeting follows on from our meeting on the same subject on 19 January at which the Institute of Obstetricians and Gynaecologists and the HSE made presentations. On behalf of the committee, I welcome Professor Louise Kenny and Dr. Peter Boylan of the Institute of Obstetricians and Gynaecologists and Dr. Krysia Lynch and Ms Breda Kearns of the Association for Improvements in the Maternity Services Ireland.

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

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

I ask Professor Kenny to make her opening statement.

Professor Louise Kenny: My colleagues at the Institute of Obstetricians and Gynaecologists welcome the opportunity to once again discuss the implementation of the national maternity strategy 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 members 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 two examinations - a dating ultrasound in the late first trimester, followed by a foetal anomaly scan, usually performed between 19 to 22 weeks' gestation. The main purpose of the anomaly scan is to screen for structural foetal 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 on 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* foetal 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 published data on this topic in 2007 and 2012. In the last two weeks, we have repeated this exercise. We conducted a nationwide survey of all 19 maternity units in Ireland and we discovered that anomaly scanning is offered universally to all women in seven units, selectively to some women in seven units and not at all in the remaining five units. Overall in 2016, more than a third of women attending antenatal services in Ireland, some 23,000 women, did not receive a foetal anomaly ultrasound.

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 health care 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 foetal 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 health care 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 without further delay. Irish women and their families deserve it.

Chairman: I invite the Association for Improvements in the Maternity Services Ireland to make its opening statement.

Dr. Krysia Lynch: I thank the Chairman and members of the committee for the opportunity to present here today on behalf of the Association for Improvements in the Maternity Services Ireland on the national maternity strategy for Ireland 2016-2026. When we were invited to participate on the steering committee of the national maternity strategy by the then Minister for

Health, Deputy Leo Varadkar, we were in a position to inform the steering committee on the views and opinions of women and their families based on our 2014 survey of 2,832 users of the maternity services in Ireland. All the main issues highlighted in our survey were replicated in the public consultation carried out as part of the national maternity strategy, and we refer the joint committee to them. AIMS Ireland was delighted to see the strategy published in January 2016 and hopes to see its full implementation. As the public consultation showed, the key issues for users of Ireland's maternity services are: choice in model of care; geographic equity in the provision of care; the importance of informed consent; partnership and trust between caregivers and service users; the lack of midwifery-led services, despite the overwhelming international evidence to show it is the safest model of care for women experiencing a straightforward pregnancy; the lack of community midwifery and home birth services; sub-optimal breast-feeding support; an inadequate provision for peri-natal mental health; the lack of service user representation at local, regional and national levels; and the lack of adequate advocacy and audit services. AIMS Ireland welcomes the inclusion of all these aspects in the recommendations of the national maternity strategy. There are several areas which we feel need to be implemented without delay.

Firstly, all women, irrespective of where they live, should have access to the three pathways of care - supported, assisted and specialised. These should be available in the three different settings outlined in the strategy, namely, at home, at an alongside birth centre and at a specialised birth centre. The latter already exist in all our units, but an alongside birth centre is only currently available in a handful of units, and there is only one unit offering a home birth service at present.

Secondly, we urge the Minister to implement the recommendations associated with peri-natal mental health. Outcomes and safety of maternity care are generally measured in terms of physical mortality. The experience of giving birth is both physical and emotional. We feel that women's emotional well-being also needs to be evaluated and addressed in terms of safety and outcomes. The area of peri-natal mental health remains particularly under-resourced, yet admittedly conservative figures show antenatal depression and anxiety rates of 17% to 18% and post-natal depression at 18% to 19%. While there are current plans to invest in specialised mental health services, women with sub-clinical conditions such as depression or anxiety will not be covered under these plans. We see the need for improved provision in this area as vital.

Thirdly, the most frequently commented on area in the public consultation related to the sub-optimal provision of breast-feeding support. Breast-feeding is a building block for the future health of the nation. We urge the Minister to ensure the implementation of the national breast-feeding strategy and also ensure that adequate importance is placed on the breast-feeding recommendations within the national maternity strategy.

Ms Breda Kerans: I thank the chairman and members of the committee. The first recommendation of the national maternity strategy was that an implementation plan be set in place within six months of the strategy being published. It is our understanding that there is still no implementation plan in place. If an implementation committee has been formed, we have not been invited to participate. For the women and their families currently using the services, the national maternity strategy has changed nothing so far.

Speaking as a rural service user, I would like to highlight three things to the committee. Firstly, the options of care and birth choices in Ireland remain a postcode lottery. This is especially true for women living in rural areas where choices are currently extremely limited, where individual clinicians are able to determine ethos and approach to care and where the threat of

hospital closures and the need to travel even great distances in labour remains very real concern. We would urge the Minister to ensure that timely access to maternity services remains an option for all rural women, and the threat of small maternity unit closures is removed. We understand that in Northern Ireland rural smaller units became alongside birth centres if they were unable to maintain full tertiary services. Other options also exist and are referred to in our briefing document.

Secondly, the woman's experience still remains undervalued and is rarely used as a learning tool. The need to fully and independently audit women's experiences is vital and is alluded to in the recently published national standards for safer better maternity care. This should be acted on without delay.

Thirdly, the area of informed consent remains a concern for women. Last year a woman was taken to the High Court - Ms B *v*. HSE - in an effort to override her right to informed choice and informed refusal. Ms B won her case. In order to avoid further such cases, at expense to the taxpayer, and threats to women of the High Court, we would like to see the strategy's recommendations regarding informed consent and informed refusal implemented in all care settings as soon as possible.

It is our view that many aspects of the maternity strategy could be implemented by restructuring services. While some areas are resource-heavy, many are not. It is our view that the national maternity strategy will be unlikely to be implemented in full. The primary reason, in our opinion, is not due to lack of resources or funding, but due to the threat that the strategy poses to the *status quo*. It is also our view that, despite the admirable intention to place the woman and her family at the centre of care, the strategy's recommendations are being cherry-picked to selectively increase resources in particular areas of maternity care at the expense of others.

Chairman: I thank the witnesses for their opening statements. I will now ask members of the committee to submit their questions. The first group is Senator Colm Burke, Deputy Margaret Murphy O'Mahony, and Deputy Louise O'Reilly.

Senator Colm Burke: I thank the witnesses for their presentations. A main concern with maternity services is that reports are produced and, as has been highlighted this morning, strategies are not being implemented. A 2003 report recommended that there should be 180 consultants by 2012. Is it possible to outline the number of whole-time equivalent consultants that are currently employed, and how far short of the 2003 target are we? Are there sufficient people in training to enable planning for the next three to four years? If positions are advertised, are there sufficient people coming on stream to fill those vacancies?

On the anomaly scans, the witnesses are saying there are a number of units that are not able to provide that service. What needs to be done to ensure that every woman has access to this facility, whether in her own unit or in an adjoining unit? What staffing numbers are we talking about? Do more people need to be trained or do we need to employ more people, and in what numbers? There were 23,000 women who did not have the facility of that scan. What timescale would be needed to ensure that the service is available to every person who is pregnant?

Deputy Margaret Murphy O'Mahony: I thank the witnesses for attending the House. I would like to commend Dr. Lynch's comments on mental health. People always think of the physical side of giving birth, yet the mother's mental health is a huge part of it. This should form part of any strategy in the future. It was noted in the strategy that pre-conception care has beneficial outcomes for both the mother and baby, yet 66.5 % said they did not access any

pre-conception care. Are there plans to increase awareness of this, and how could this be done? During the meeting in January I raised the issue of fertility, which should form a huge part of this plan. Maternity care should start with people who are finding it hard to conceive. Emphasis is put on events starting with a pregnant woman's first visit to the gynaecologist, but many people experience much pain and hardship before that stage is reached. Do the witnesses think a fertility section should be included in this strategy?

Deputy Louise O'Reilly: I wish to thank the witnesses for coming in and sharing their experience and knowledge with us. I have tabled several parliamentary questions for the attention of the HSE on the 20-week scan, on which I feel very strongly. The response to one question was sent and then amended. It had initially said that 20 to 22 week scans are routinely provided to patients in certain hospitals, but subsequently clarified that by saying they are available to patients in those hospitals. How would one know that a 20-week scan was clinically indicated, if the scan itself is supposed to be a screening tool? To what extent might a woman herself know? This type of scan is considered fairly basic in most developed health services. What are the barriers to women being able to access this routinely? Could the witnesses break that down into the following three sections: equipment, training and ethos? A family member of mine had her first baby in England. When she came home to Ireland to have her second child she asked about the scan, assuming it was routine. A very off-the-cuff remark was made to her, indicating that these scans are not done in Ireland, abortion is not available in Ireland, and she was not in England any longer. I wonder to what extent that is a barrier. I believe it might be but I would be interested to know if the witnesses could shed some light on that.

Are there staff shortages for providing post-birth support? I am referring specifically to breast-feeding, which some women will struggle with, particularly if there is no time for staff to sit with her and help her, or if she lacks familial support. A midwife recently indicated to me that breast-feeding among members of the Polish community is up at 95% to 98%, even though these women are giving birth further away from their families in many instances. What is the problem with breast-feeding for Irish women? It is a long time since I had a small baby, but I understood it to be a cheap, easy and convenient way to feed a child. I did not have any issues with it. I thought it was very handy, but I am wondering what the barriers are. Is it a staffing issue? Is it that after a woman gives birth she is handed the baby on the way out the door, told she has now done the hard bit - obviously she has not - and she goes home? Do women need someone who can sit with them to assist with breast-feeding?

Is there a model for peri-natal mental health supports that we can look at? Is there another country with a gold standard?

The witnesses from AIMSI said that there is cherry-picking of resources, placing some areas ahead of others. Perhaps they could outline what was meant by that.

Chairman: Does Professor Kenny wish to answer some of the questions posed?

Professor Louise Kenny: To answer Senator Colm Burke's question on consultant staffing levels in Ireland, as per our previous submission to this committee, the number of consultant obstetricians and gynaecologists in Ireland is the lowest in the top OECD countries, at 3.95 per 1,000 live births. Ireland has a high birth rate, so the number is even lower when corrected for birth rate. Dr. Boylan will speak more on this, but it is estimated by the Institute of Obstetricians and Gynaecologists that we need to appoint another 100 consultants to bring Ireland up to anything like international norms. As for whether we have sufficient capacity in the system at the moment, it is well-known that Ireland trains some of the best doctors in the world. Those

doctors currently staff the units of Australia, New Zealand, the UK, Canada and America. We would love to bring some of our trainees home. Currently, they will not come home because of divisive contract, because the working conditions here are appalling and because they are better serviced in other countries. We believe we would have capacity to increase consultant numbers over the next five years in a phased way. I do not think anyone would favour suddenly creating 100 posts because we do not have 100 high quality trainees to fill those posts at the moment. However, a phased recruitment strategy would be very welcome.

In answer to the question on anatomy scans, I do not think there is one solution that will fit all units as the problems vary. I would strongly argue that this is not an unfixable problem. Ireland does not need to find expensive and scarce radiographers, who are not plentiful here. Midwives can be trained to a standard sufficient to perform foetal anomaly scanning. There is a recognised diploma in Dublin which takes two years, but within three months of commencing that training midwives on the course can perform routine first trimester scans. In a unit like mine, this would free up other specialist individuals who could then perform the anomaly scans. If there were backfill for the people in our units who have completed training, and a few extra midwives could be trained, it would be possible to fix the situation in our unit within six months. That is not the case in some other units, where lack of equipment and lack of personnel are more problematic. Nevertheless, significant inroads into this problem could be made in a very short period of time. It is not unfixable.

Pre-conception care means different things to different people. I provide a pre-conception care service for women with complex medical issues who are contemplating pregnancy. It is very beneficial for women who, for example, have epilepsy and are on complicated medical regimes, or women who have diabetes. This is not uniformly available across the country; I think it is only available in the big units. Increasing problems with obesity and older maternal age are significant public health issues. An increase in availability of pre-conception care would be welcomed, but it would require significant resource allocation. As an obstetrician, a gynaecologist and a mother, I completely agree that fertility should be part of the package of care that is provided. It is flagged within the national maternity strategy.

Returning to Deputy O'Reilly's question about whether an anomaly scan is clinically indicated, that is exactly the point in question. This is a screening test and it should be uniformly available to everybody who wants it. I make decisions on a daily basis as to who should receive this scan and who should not and it results in foetal abnormalities being missed in women who are perceived to be at low risk. The vast majority of abnormalities occur in low risk pregnancies.

Equipment is not the fundamental barrier to routine access. Admittedly, the equipment is specialised, expensive and has a shelf life, but it is not, in my experience, a barrier. There are staff training issues but, as I previously discussed, we have the capacity to train midwives to a very high standard to perform this service. In my unit at the moment we cannot release those midwives from other clinical areas. If we were to release them, their positions would not be backfilled. We also have three midwives who have completed the course and who can function as very highly-trained midwife sonographers. However, their qualification has not been recognised, they have not been moved up to the clinical nurse manager 2 grade and they are not being remunerated for that work. As a result, they are staying within the clinical service. We have the capacity to change the system, but not the power to do so.

I do not think there is an ethos that is providing a barrier to provision of the 20-week anatomy scan. This scan detects often treatable abnormalities, and facilitates better delivery

care planning. I do not believe anyone in Ireland currently is not having this scan because of a pervading ethos. That question is pertinent for first trimester screening. The UK is now moving towards routine non-invasive pre-natal testing, which is a very safe and highly effective way of screening for foetal abnormality in the first trimester. The routine roll-out of first trimester screening might come across a barrier of ethos. However, we are many years away from being able to consider the provision of that service when we still cannot routinely offer 20-week anatomy scans.

Breast-feeding initiation rates are going up in Ireland, which is very pleasing for anyone involved in this area to see. Initiation is one thing; maintenance at two months or three months post-delivery is quite something else. Speaking as a mother rather than a doctor, the fundamental barrier to breast-feeding is our lack of ability to provide post-natal care in the community. I had my children in the UK. During my first pregnancy I was visited by a midwife on a daily basis for two weeks, and that was critical to me being able to establish breast-feeding. We do not have that service in Ireland, and I think that is the number one barrier to maintenance of breast-feeding.

Chairman: I thank Professor Kenny.

Dr. Peter Boylan: Ten new consultants per year need to be appointed for the next ten years, in addition to the replacement of retirees. Retirements are entirely predictable, as the age of all consultants is known and they currently have to retire at the age of 65, although some have continued on beyond that.

There are enough trainees coming through, but the jobs are not attractive enough to them. Making our jobs attractive enough for consultants to apply for them is one of the major hurdles that we face in the Irish health care system. When I addressed the committee previously, I pointed out two jobs which were illustrative of this. The first was a job between the Rotunda Hospital and Drogheda, which would be a very attractive job as a consultant. There were no applicants for that job, which is astonishing. The second example is a job between the National Maternity Hospital and Mullingar. It also would normally be regarded as a very attractive proposition. There was one applicant from Lithuania and she withdrew before the interview. That job has not been re-advertised. That is the reality. Something needs to be done to make those jobs more attractive. The contractual issue is the major one, as well as working conditions, infrastructural deficits, working hours and so on.

There are only three part-time peri-natal psychiatrists in Ireland and they are all based in Dublin. That is just not acceptable in 2016. There are no mother and baby units in Ireland for women who have breakdowns or who become severely distressed or depressed after delivery. Those women's recovery would be much better were they in a mother and baby unit, of which there are about 20 in the UK. Those are two deficiencies which can be addressed.

There is only one clinic in the public hospital system offering assisted fertility techniques such as IVF. The other clinics are either private or have been bought by international IVF organisations, or businesses, basically. They are in it for the business. That needs to be addressed. For a couple having difficulty in achieving a family, the transformation when assisted is quite dramatic.

Professor Kenny has addressed the 20-week scan. I do not think ethos is a barrier but, as Professor Kenny said, first trimester scanning and the routine offering of screening may cause difficulty for some working in the Irish health service. However, this service should certainly

be available.

Chairman: I thank Dr. Boylan.

Dr. Krysia Lynch: I thank the members for their interesting comments and questions. I will not address staffing levels - obstetric, NCHO or midwifery staffing levels - as that is not my area of expertise.

Deputy Murphy O'Mahony asked about pre-conceptual care. She highlighted a very interesting aspect of maternity care, which is what the woman or the family experiences. This experience is a continuum. It is very easy for those involved in planning for services or delivering a particular part of the service to see just their area, or to see it broken down into very convenient slots. For a woman and a family it is a continuum which might have started when the woman held a doll when she was five years old, thinking she might like to have a baby one day, and later finding out that maybe there are difficulties along the way. Women report that issues associated with sub-optimal fertility or issues associated with fertility that they encounter can be difficult because often it is necessary to use a private service, which is not equitable. Women who are medical card holders or who cannot afford private care find that waiting lists in the public service are very long, and that it is necessary to fulfil certain criteria. For example, women can be older if they are can afford private care but must be younger if they are in the public system. That is one issue women report.

Pre-conceptual care is best addressed in the community. Most community care associated with pregnancy and childbirth is a one-to-one between a woman and her GP. Women who are healthy may not go to their GP very often, so they may not have that connection. The national maternity strategy recommends an increased provision for community midwifery, not just in attending births, but having a community midwife in a doctor's practice. These midwives could engage with areas of society which are more difficult to engage with and which we know have poor engagements with health, with different women's groups and with different ethnic minority groups which may not have those close connections that perhaps women born in Ireland would have with their GP. The greater emphasis on community care and community midwifery care in the strategy could address this issue. In the UK, it is common to have a midwife in every GP's practice which we do not have here. Our GP practices are moving from practices with one GP to practices with several GPs and a midwife. There is an insurance issue there. It is possible to obtain insurance for a GP to have a practice nurse, but not necessarily a practice midwife. That is something that can be looked at.

Of the four witnesses here today, I was the only representative on the national maternity strategy steering committee. The steering committee was presented with a series of definitions and terms of reference. Looking at fertility and gynaecology was not within our remit. It was already presented to us *de facto* at the very first meeting that they would not be included. I am not certain as to the reasons, as they were beyond our deliberations.

Professor Kenny has alluded to the fact that a scan is a choice. Not every woman chooses to have a scan. Not every woman would choose to have an early first trimester scan to find out if there were any issues associated with the pregnancy and not every woman would choose to have an anomaly scan where she has an opportunity to have one, so we always have to bear in mind that not everybody necessarily wants to know. Even though we, as advocates, or the medical profession may think it is unusual, some women do not want to know.

I first came across scans, and issues associated with scans, in the miscarriage and misdiag-

nosis furore that erupted in 2010 where we started to see that there was great inequity in terms of scans, scanning equipment and the ability to understand and diagnose things from scans. My understanding is that our capacity in that area in terms of training has unquestionably improved and that when the capacity is there to actually perform the scans we have the expertise, as Professor Kenny said. We have adopted things like early pregnancy assessment units where women who are perhaps experiencing question marks around their pregnancy do not have to sit in the same area as women who are having a full term, happy pregnancy, if one likes, so we have those issues.

On the questions associated with abortion, we have reports about first trimester scans where women feel that in certain units they are not being offered a foetal scan, an early scan, but I do not think that is really the case for the second trimester scan.

There was a question about breast-feeding and I would like to say something about that before I let my colleague respond to the rest of the questions. It is very interesting because there are so many different rates. If one were to Google "breast-feeding Ireland" the very first thing that will come up from the search is a web page that is monitored and run by an artificial formula company. That indicates some of the issues associated with breast-feeding in Ireland. Our rates hover around 50% and the initiation rates are much better for some units than others. Although he has left the National Maternity Hospital, Dr. Boylan can take a bow, since it celebrated a 72% initiation rate this year which is very high but it can be as low as 40% in other units.

The Polish contingency, and having a Polish background I wave a little flag there, are possibly responsible for some of those rates in certain areas of the country. However, when AIMS ran its survey, one in four women indicated that she found her breast-feeding support as poor or very poor in hospital. What does that mean and why is that? One of the key issues was that there was not lactation consultants on duty during out-of-office hours. Unfortunately, babies do not just want to feed in office hours, they want to feed at the weekend and in the evening and mothers give birth in the evening and over the weekend, so that is an important issue that needs to be addressed in terms of staffing. Also, and I suppose this is a staffing issue, post-natal wards are extraordinarily busy. Some post-natal wards in the busy hospitals in Dublin will have a midwife to woman ratio of 1:18. We have a huge number, and an increasing rate, of caesarean sections, with more medicalised births - more or less one in three - so those midwives are having to deal with women who require pain medication, women who are perhaps recovering from surgery and they have to triage. Breast-feeding a woman on her third baby will probably be lower down a list for a midwife's attention. Increasing the number of midwives, especially in post-natal care, is very important.

If we look at the rates from hospitals, they are about 50% but if we look at the audits that have been done on community care it is different. If one looks at the annual home births audit for Ireland, which is carried out by the National Perinatal Epidemiology Centre in University College Cork, for example, the initiation rate is 99.7% and the continuation rate at discharge, which is between two and six weeks, is 97%, so that follows on from Professor Kenny's response that community midwifery is very important and perhaps different models of care are important because those same high rates are again replicated within midwifery-led care led options, although they are not quite as high.

My final point on breast-feeding is that we have issues with the World Health Organization's code of marketing of breast milk substitutes in Ireland. Artificial milk is available to mothers when it should not be and it is offered to women where there is no clinical reason for offering it.

Those breeches of that code are part and parcel of the issue. For example, one can see bottles of formula just left around in post-natal wards but that should not happen. In conjunction with that, the WHO and UNICEF have established a baby-friendly hospital initiative which some Irish hospitals are signed up to, although some are not. I think the strategy recommends that all hospitals should try to achieve that status.

Chairman: I thank Dr. Lynch and call Ms Breda Kerans.

Ms Breda Kerans: Senator Colm Burke mentioned staffing numbers. I come from the west of Ireland and from a rural perspective, it is a huge issue and retaining staff is a huge issue. I know it is an issue for all the hospitals but there is quite a dependency on agency staff which has a knock-on effect across the board and it is certainly a safety issue. AIMS would like to see the dependency on agency staff reduced dramatically. Other countries have addressed this issue in rural areas, particularly when, as in the west of Ireland, there is a small population which widely dispersed. Countries such as New Zealand, Australia and Canada have put in place specific strategies in order to retain staff in those areas. For example, one strategy that most of those countries have put in place is that when staff come from abroad, they are obliged to spend a certain amount of time in a rural hospital before they can go to the larger teaching hospitals. They have also employed strategies around staff rotation in order to keep competency levels at the required level, so that somebody is not necessarily working in a rural hospital for prolonged periods of his or her career and that is something AIMS mentioned in its submission to the maternity strategy and which we would like to see considered because it is happening in other countries.

Hospitals in rural areas, and particularly in the west of Ireland, have probably the lowest levels of anomaly scanning, unfortunately, and that lack of access to anomaly scanning is reflected in many of the cases that have arisen in recent years. We were contacted by the mother of baby Conor Whelan in the last number of days asking us to put in a plea to the committee to make sure that the maternity strategy is implemented in this particular area. She strongly believes her baby would be alive today if anomaly scanning was available and that is incredibly sad.

An issue that has arisen in rural maternity hospitals is that midwifes are often trained but cannot be retained. A number of units have trained midwife sonographers who have then left because there are better working conditions abroad, as Professor Kenny, already mentioned. Once they have completed their training, it is more attractive for them to seek employment abroad. Initiatives could be put in place around retaining staff who have been trained. For example, part of the training package could be that they must sign up to remain within the service for a certain number of years, which would at least go some way to addressing that. On the timescale for implementing something like that, it would very much depend on the willingness of the HSE to put funding in that area and training.

A number of members raised issues around mental health and it is an area in which Ireland is far behind compared to other jurisdictions. In the UK, for example, the former Chancellor of the Exchequer, George Osborne, put a £1.2 billion package in place to address perinatal mental health about two years ago. This was on the back of a report commissioned by the Maternal Mental Health Alliance which showed that expenditure of an additional £337 million was needed to bring NHS mental health care to a recommended level. In response, George Osborne committed £1.2 billion to be spent on an expansion of mental health services for children and mothers of new babies. The reason he did that was that we now know that the impact on infant development of undiagnosed perinatal mental health issues is absolutely huge and the cost of that to a country is enormous. That particular report suggested that there was a cost of

£8 billion per year to the UK economy of undiagnosed and untreated perinatal mental health issues. One can see that it is an area well worth spending money on. It is something about which many women regularly come to us. In Ireland, our mental health services as a whole are under-resourced. There are communication issues between maternity services and mental health services and there are issues around data protection and confidentiality. Pre-conception care also plays a part for women who experience perinatal mental ill health. For example, for women who have experienced bipolar disorder, it is vital that pre-conception counselling takes place. Many would be on medications that need to be monitored during pregnancy, etc. I sit on a perinatal mental health group that has been recently set up in University Hospital Galway, and it has been eye-opening for everybody involved. When one has psychiatrists and mental health teams sitting down with maternity services, it is eye-opening for all sides. Very often, women going to maternity services will not necessarily divulge that they are patients of mental health services and, *vice versa*, when they are seeing their mental health teams, for a significant part of their pregnancy, they may not divulge that they are pregnant. Communication is a vital tool here, and there needs to be a lot more integration with mental health services. As Dr. Boylan said earlier, there are only three part-time perinatal psychiatrists in the country, and they are all based in Dublin, which is, in itself, very telling. There are no perinatal mental health psychologists in Ireland. By contrast, in France every unit has a perinatal mental health psychologist. The lack, or poor standard, of post-natal care in Ireland, both in hospitals and in the community, leads to many women being undiagnosed. For example, we have no screening policy for post-natal or ante-natal depression in this country. As Professor Kenny mentioned, in the UK women would have visits from health professionals, and the Edinburgh post-natal depression scale is used to screen for post-natal depression. It is a separate issue, but most units here are seeing an increase in ante-natal anxiety and post-natal anxiety, as distinct from depression. We are not screening for either. Many women are fearful of disclosing that they are suffering from post-natal depression or ante-natal depression. They are fearful of involvement of child services, a fear which is often unwarranted as most women would be treated very well, but it is a stigma that we need to address. That comes about through education, and women being educated very early on.

Practically everything else I wanted to talk about has been covered. I know cherry-picking was mentioned earlier. We would be particularly concerned about whether all models of care get an equal bite of the cherry, because that is what is best for women. In particular, post-natal care has been the forgotten part of maternity services for a very long time, and it definitely needs to be addressed. In most regions of the country, women are lucky to see a public health nurse once or twice maybe, at most. This has been reduced significantly over the years. When I had my first baby 24 years ago, I saw my public health nurse four or five times. That is now a thing of the past. A post-natal stay in hospital 24 years ago for a normal vaginal delivery was five days, in my case. That was to ensure that the mother was well, that she was emotionally well to go home. Most women are now home in a day if they have a normal vaginal delivery and, for caesarean section mothers, three or four days, maybe. There is very little assessment done as to what care or support a woman has at home.

Many women have emigrated here and, therefore, have very little support at home. Many Irish women live far away from their own families. These are all issues that we are afraid will get less attention when the strategy is implemented. This is particularly true for models of care. We feel that home birth and midwifery-led care should play a large part in the delivery of the service overall, in terms of reducing the pressure on high levels of obstetric-led care. If women with normal low-risk pregnancies are going through the same system, it affords obstetricians less opportunity to spend time with high-risk women.

Chairman: I thank Ms Kerans. Before I bring in Deputies Kate O'Connell and Bernard Durkan, I have a number of questions for the witnesses. Surely the 20-week scan is a medical necessity rather than an option. I would imagine that both the first trimester scan and the anatomy scan are of medical importance, so it should be an absolute necessity to offer it rather than an optional offer. Is there a minimum size for an obstetric unit to be safe in delivering children? Smaller units may take the low-risk pregnancies and have the high-risk transferred to a specialised unit, but what would be the minimum size for a safe obstetric unit? On the last occasion Professor Kenny and Dr. Boland referred to the mastership model in regard to the governance of maternity hospitals, and expressed the view quite strongly that the mastership model was a much more efficient and effective model in regard to governance, responsibility and accountability. When Mr. Liam Woods, interim national director of the acute hospitals division, gave evidence on the last occasion, he did not hold that view. He did not think a mastership model would be an appropriate model for use in Cork . Perhaps the witnesses might think about those questions.

Deputy Kate O'Connell: I am sure the witnesses do not have to think too much about the last question.

The statistics provided by the Institute of Obstetricians and Gynaecologists indicate 36% of women attending ante-natal services in Ireland have no 20-week scan. Could the level of potential adverse events as a result of that lack of scanning be extrapolated? Perhaps the witnesses could discuss the professional difficulties doctors and midwives may encounter as a result of being presented with a disaster zone that could have perhaps been avoided. I think I am right in saying that Ireland has an increasing rate of neural tube defects. I could be wrong, but I read that at some stage. This is preventable in many cases with adequate pre-natal nutrition, such as sufficient folic acid consumption. As a community pharmacist, I am mindful that folic acid is one of the cheapest products available and that there is a lot misinformation around it. Before I took up my role as a Deputy I regularly encountered women who were taking whatever vitamins they had at home and using them up before they went out and bought new vitamins. I have worked in the most deprived parts of the country as well as in some of the most affluent parts. There is a huge lack of understanding throughout Irish society about adequate nutrition and preparedness for becoming pregnant, should one be so lucky for that to happen. It is all fine saying we can do a non-invasive tests, and I had one on my last child, but perhaps if the witnesses have the data with them, they could inform the committee of how we can avoid preventative birth defects. My understanding is that the neural tube defect rate is climbing at a higher rate in Ireland than anywhere in the OECD. Free folic acid for everybody would be such a cheap measure. I know there are issues around safe upper limits because it is a water-soluble vitamin, so there are issues around how much one can take. I would like the witnesses' views on prevention rather than cure.

On post-natal depression and breastfeeding, I was privileged enough to be a private patient in the Coombe for my three children but on my last child, there was no private bed available and I was in a public ward. My first child had a birth defect which was discovered at the 20-week scan. I paid privately to see a paediatrician in advance of his birth because I knew that there would be a separation at birth and there would be an issue in terms of establishing breastfeeding when the child was in the intensive care unit and I was elsewhere. However, my understanding is that was only because I had the wherewithal to do that. For people in such circumstances, is there any similar system in place to address that? I was lucky enough to have a mother who is a nurse and lots of sisters to help me out but I felt that it was my own call. It all worked out but is there anything for public patients to address this issue, that is, support for women who are

separated from their child at the point of birth to breast-feed?

Are there better pre-conception regimes in place in other countries and do the witnesses have any data regarding how this transfers to birth defect rates and mental health outcomes and breastfeeding outcomes for families?

On supports for public patients in the hospitals, maybe it is different in Cork and in other hospitals but I was handed what appeared to be a typed pink document and was told to go to a breastfeeding class but I had a caesarean section and could not walk. I was just handed this document and told to go to the class. I cannot remember if it was in the morning or in the afternoon. The last place a person wants to be is in a breastfeeding class with women with babies while one's own baby is in intensive care. I could not think of any worse place to be.

On the correlation between home births and breastfeeding, we were given a figure of 99.9% but I imagine we could drill down into that data more, that is, that women who choose a home birth are perhaps just more engaged with the whole birthing experience and that having a home birth means a person is more likely to breast-feed. I would like that correlation clarified.

On rural service users, we referred to the mastership model and clinical directors being appointed and to how birth defects do not happen only to people in risk situations. How can we say it is a good idea to have rural home births or rural units when we do not have adequate scanning? Are we going to end up with potential catastrophic incidences? I am all for it but if we do not have adequate scanning and things in place to prevent bad incidences at birth, how can we even consider people having babies far away from teaching hospitals and centres of excellence? I am concerned about it.

I was 30 years of age when I had my first child but the defect he had was more likely in teen pregnancies. If I had not had a 20-week scan and if I was in a rural hospital, my first child probably would not be alive. Is it realistic to expect that clinical directors and doctors could stand over units dispersed around the country when we do not even have the scanning in place? I hope the witnesses from AIMS might be able to straighten that out for me.

Someone mentioned there were no mother and baby units. What happens? Does the mother go into a psychiatric unit and the baby go somewhere else? I did not know this happened. Could this be spelled out for the committee because I was unaware of it and it is deeply concerning? God almighty, if a mother was on the edge already, then to take her baby away and put him or her somewhere else would definitely finish her off altogether.

In France, every unit has a perinatal psychologist. Have we any data about outcomes for families and mothers? If we had one, would we get better breastfeeding and better experiences for families?

On post-natal depression, I am a community pharmacist but I would like to hear the witnesses experience of this, which would be far greater than mine. However, I have come across women with post-natal depression but they are afraid to go to their GP or consultant because they do not want to be prescribed an antidepressant as they are concerned about breastfeeding. Their attitude is that they will suck it up and get through it because they are breastfeeding and that if they go to the doctor, they will be given medication and they are afraid of harming the baby. Is the lack of openness about this whole issue preventing women from going to their doctors or midwives?

My understanding was that public health nurses had to have a midwifery qualification but I

am obviously wrong because the witnesses are shaking their heads. If we were to move towards having a midwife in a GP practice, would that get rid of the need to have public health nurses or are they two things that would work in tandem?

Deputy Bernard J. Durkan: I thank the Chairman and the witnesses for giving of their time, expertise and vision. I think I have mentioned before that interaction between medical practitioners and mainstream politicians has not taken place for some years. As I have said many times, I was a member of the former Eastern Health Board. Questions were raised at health board meetings and responses were expected but that has not been happening in terms of the general debate that should be taking place around medical services.

Data protection was mentioned but to what extent does it impede or assist the delivery of maternity services? Maybe the witnesses could give an example. I will not go over the question raised by my colleague on dietary advice during pregnancy but it is hugely important and plays a vital contribution that is underestimated. In a previous existence, much more emphasis seemed to be placed on that particular element.

What do the witnesses believe needs to be done in terms of the implementation of the national maternity strategy?

Another issue that has been raised many times is the attractiveness of the medical profession at GP and consultant level and so on. We heard earlier about a post that was advertised in respect of which only one application was received. If that is the case there is something seriously wrong in terms of what we are doing that needs to be addressed urgently. We need to look at the reasons a position may be unattractive. For example, is it because the impression among the public is that the quality of services in a particular area are poor by virtue of reputation or incidents that have occurred that could have been avoided if different practices were followed? I am aware of a number of vacant GP posts in my own area in respect of which only one or no applications were received. Nobody wants to apply for a position that is deemed to be unattractive. Who would want to apply for a job that is going to be abolished, for example? Who would want to become involved in the delivery of services that previously have been so deficient that the life of a patient was put at risk? I would welcome a response from the witnesses to those questions.

The GP service is crucial to every person in the country. It is a service that we all have to avail of at some point in our lives. It is important that we establish the fundamentals of what we need to do now taking into account the budgetary position we are in. If we do not address this problem now we will still be talking about it five years down the road. We need to address why particular positions are so unattractive otherwise the problems we are experiencing now will be multiplied, with serious consequences.

It was mentioned that there are only three part-time peri-natal psychiatrists in the Dublin area. It is important that is brought to the attention of the Minister at the earliest opportunity. We are all aware of the tragic events that have occurred. Following any event, there is always much talk about things should be done differently. I am sure that our experts are in a better position than anybody else to set out five initiatives that if implemented could have a dramatic impact in terms of the elimination of the type of tragic events that have occurred over the past number of years. It is a long time since there have been babies in my household but I come from a family which during my childhood had many tragic experiences.

Professor Louise Kenny: I will respond first to the questions around anatomy scanning.

By way of clarification, the purpose of the minimal ultrasound schedule is to accurately date the pregnancy, diagnose multiple pregnancy and to plan for the management of multiple pregnancy in the first trimester and potentially to screen for abnormality. The 20-week scan is all about screening for structural abnormalities. As obstetricians, we recommend universal availability of those scans. I should emphasise, however, that women are autonomous beings and uptake of these scans is optional. In our experience, uptake is pretty much close to 100% but some women, for whatever reason, decide not to take one or both scans, as is their right.

It was brought to our attention immediately before this meeting that in response to Parliamentary Question No. 254 - Ref. No. 5055/17 - from Deputy Sean Sherlock regarding data around the availability of the anatomy scan and on when it will be universally available across the country Mr. McGrane responded that the HSE does not have that data. We have provided the data to the committee today and we are happy to share it with Mr. McGrane. We note that Mr. McGrane also states in the response that the implementation group will meet in the third quarter of this year to plan for what is required for universal anatomy scanning and that these requirements will be factored into the 2018 Estimates process, which by my estimation means that the earliest we will see any movement in this area will be 2019. Following on from that, we have provided data that show that 23,000 women in this country will not receive scans this year, next year and, possibly, in 2019. The background congenital abnormality rate is approximately 1% and so based on a very simple equation there will be 230 missed cases of congenital abnormality every year until this is fixed, some of which will be very significant. Following on from that, what are the professional and personal consequences? Women and their families are at the heart of everything we do and how personally and professionally we cope with this is secondary to the affect it has on a family. Some women have come forward in recent weeks to highlight this issue, some of whom have shared their stories with the media. Their tragic experiences have been well documented. These women have joined a campaign on social media to try to remedy this situation.

I would like to share a personal anecdote of a mother who delivered a baby by emergency cesarean section because her baby's abnormality had not been diagnosed pre-natally and therefore we could not plan for an elective delivery. The baby had an unusual condition of the heart, hypoplastic left heart syndrome. Under ordinary circumstances, we recommend that these babies are delivered in Dublin so that they can be immediately transferred to Crumlin hospital for corrective heart surgery. This baby was transferred ex utero in an ambulance and unfortunately died shortly after reaching Dublin. That may have been the case no matter what but that baby died 230 miles away from its mother, who never got to see or hold the baby during that time. I have no doubt that that will be carried with her and her family for the rest of her life.

With regard to the mastership model, Dr. Boylan, who will elaborate further on this point later, and I are convinced that one of the four most important issues in terms of address of all of the issues we have spoken about during this meeting and previously is governance. If we had independent clinical and executive governance, whether through the mastership model or an empowered clinical director, which are the same thing in most units and across other jurisdictions, we could start to fix most of these problems immediately and fix most of them in a short timeframe. As I outlined, we could probably fix the issue around anatomy scans in our own unit in about six months but we do not have the freedom to operate to do so.

On the issue of catastrophic incidents without scanning in terms of home birth and the domino scheme, we have prioritised women who are taking part in the domino scheme and our home birth service in Cork for anatomy scans. They do have anatomy scans for that specific

reason. I agree that that is essential for women who are planning to deliver in areas remote from a hospital. With regard to post-natal mental health, a mother who develops significant post-natal mental ill-health such as, for example, puerperal psychosis, is separated from her baby and often by many hundreds of miles. This is fundamentally bad for clinical care and outcomes. When a mother is separated from her baby, the issue that has led to that separation in the first place is compounded. The ethos of a mother and baby mental health unit is to keep mothers with their infants during those critical weeks as they are on the pathway to recovery. The absence of them is another facet of unequal care in Ireland for women in 2017.

Dr. Peter Boylan: I will not go any further into the 20 week scan issue as it has been addressed fully by Professor Kenny.

With regard to neural tube defects and folic acid supplementation, the easiest way of getting around that is to supplement food on a nationwide basis. Education is essential and to be recommended but it will not work. We should supplement food in the same way that we put fluoride in the water, which helps our teeth. I do not see any problem with it, apart from objections by some people who will object to everything, including vaccines and so on. We should just go ahead and put the folic acid into the food.

With regard to the separation of the baby from the mother at birth when the baby has an anomaly that needs intensive care, the programme, which is the only one I can speak about but I am sure the position is the same in Cork and in the other Dublin maternity hospitals, is that conferences are held on a weekly basis attended by paediatricians and obstetricians. We get consultants in from the children's hospitals on a regular basis to discuss particular problems that have been identified. The parents meet the paediatricians or the surgeons afterwards so that there is a plan for the delivery. They have met the surgeon who will operate on their baby after its born and the paediatrician who will look after the baby. That would help in that respect.

Where diagnoses are made for women who live in more rural areas or distances from Dublin, those women will be transferred to Dublin for consultation or to Cork in the southern area. They would attend regularly and a decision is then made on the most appropriate place for them to deliver. It is almost always in the major unit so that they can have easy access to care afterwards by the paediatricians and-or the surgeons.

With regard to home births and breastfeeding, if we consider social grading or class, to use that word, and education levels, home births are much commoner among highly educated women who tend to breastfeed more. There may be a correlation with that and as the Deputy said, there is more of a buy-in to the whole birthing experience and so on. The low rates among Irish women are probably cultural in nature and it will take a long time for that to be addressed sufficiently. There is a hangover effect in that regard. We have addressed the issue of mother and baby units, the separation aspect and those women who have puerperal psychosis or severe mental breakdowns in the post-natal period.

To address Deputy Durkan's issue regarding data protection, I am not sure that it has any influence whatsoever. The doctor-patient relationship is an extremely confidential one. By virtue of our ethos, guidelines and practice we are not allowed discuss patients outside the arena of the clinical world. It is a very serious issue to break confidentiality in regard to patients in any way whatsoever.

In terms of what needs to be done to implement the maternity strategy, a few things can be done. I agree entirely with the aim that we need to introduce more community midwifery. The

Domino scheme is a very good example. Community clinics are run by midwives closer to the mothers' homes so that they do not have to travel to the clinic where they spend no more than five or ten minutes, get on the bus and go home. It is much better to have those closer to them.

With regard to the mastership model and jobs, it is interesting that where a job is solely in one of the Dublin maternity hospitals and not linked to another hospital there does not seem to be any huge difficulty in filling those posts. That is because they are working under the governance of the mastership model where they know there is a clinician in charge whom they can talk to, who will understand what they are saying and will allocate resources in the best interests of patients attending the hospital.

No matter how well intentioned a manager is who is not medically qualified, and they are well intentioned, they can never fully understand the business because they are not dealing with difficult cases at 4 o'clock in the morning. They are not dealing with all the clinical problems. They are not on the wards understanding the clinical issues. It is important that managers are there to back up the clinicians in the mastership model.

Many people have an objection to the word "master". It is a clearly identifiable term. Everybody knows what it is. The captain of a ship is the master of a ship. There is no difficulty with that. We need to get over any difficulties we have with the name. We should accept it. It is recognised, and it works.

The Minister said recently that he would fire managers who were not performing adequately. We will wait with great interest to see whether he follow through on that statement. If he really means what he says, we will see the actions taking place but we will be watching with great interest. I will not make any reference to the Skibbereen Eagle because it might be taken up inappropriately.

A question was asked about the minimum size of a maternity unit. It is an interesting question because it depends on the level of complexity of care. Where there is any issue about a complication, it is clear that care must be in a large unit where there are people with the experience who will not become deskilled by not dealing with problems on a regular basis. Currently, when problems are identified, most of those women will be referred to one of the larger centres in Galway, Cork, Limerick or one of the hospitals in Dublin. That is the way it works.

One of the problems with obstetrics is that events can happen in a completely unpredictable way. That is one of the difficulties many doctors would have with regard to home births. There is a well recognised reluctance on the part of many doctors to encourage or even accept the concept of home births. That is due to their experience of the sudden catastrophic event that can happen.

Perinatal mortality rates are very low in Ireland, and they are very low among home births, so we would need to have thousands of births to see a pattern. The unfortunate truth is that where studies have been done either in this country or internationally, the perinatal mortality rate - the death of babies - is higher among home births. My personal feeling about it, having worked in a hospital which has a home birth service and having observed some of the problems that happened in home births, is that mothers having their first babies should have their baby in hospital because it is among those births where the greatest problems arise, and sometimes completely unpredictably. The Domino scheme would be a very good compromise for mothers who want to have a home birth on their first baby. They have all of their care outside the hospital. They come in for scans and so on. They come in and have the baby and then go home

within a few hours where their community midwife looks after them. That is the same team of community midwives who looked after them in labour so they have continuity of care and the closest they can get to a home birth without any of the risk associated with it.

For mothers who have had a successful first birth without any difficulties, home birth is perfectly safe on second and subsequent births unless well recognised problems arise. They are less likely to have any problems. The institute would give a qualified support for home birth services but recognises that there are risks associated with them. It is extremely unlikely that an individual woman will encounter such a risk because the rates are so low, but it is an unavoidable tragedy when these events sometimes happen. That is not to say that there are not unavoidable tragedies happening in the hospitals. That has to be admitted. There is no question about that. If the committee wants to consider one measure that is cheap - it would not cost anything - and would improve services, it would be to change the governance models, which implies changing to the mastership model.

Much attention has been focused on Cork in recent times. Why not do an experiment in Cork involving implementing the mastership model, reviewing it after a few years to identify whether it is working and is more successful than the current model in regard to waiting lists for gynaecology, etc., and if it is shown to work as well as it does in Dublin, where it clearly works, implement it nationwide?

Deputy Kate O'Connell: I asked about women avoiding visits to their general practitioner with post-natal depression because of the likelihood that they will be prescribed a medication.

Professor Louise Kenny: There is considerable misinformation concerning the safety of medications in lactation, not only in Ireland but globally. This is an area that has not attracted much research or research funding. The innovative medicines initiative in Europe, which falls under Horizon 2020, is looking at addressing this very shortly with a large public private partnership which will establish a defined register or similar to examine the safety of commonly prescribed drugs in pregnancy and during lactation. That said, everything we know about the commonly prescribed anti-depressants that would be given to women in the post-natal period shows they are safe in breastfeeding. There is a great deal of misinformation about this and a gap in the education of women who are breastfeeding. They should be given much more reassurance than is currently available, not only about anti-depressants but also about other common medications that may be clinically indicated post-natally but are either not prescribed or not taken owing to unfounded fears about the effect they would have on the quality of breast milk.

Dr. Krysia Lynch: Members have raised many issues. I will address the comments we have just heard before responding to some of the detailed questions asked by Deputies O'Connell and Durkan. On the lactation medications, from the many hundreds, if not thousands, of women I have spoken to in the past 13 years, while the issue is partly one of a lack of understanding among the women in question, it is primarily one of a lack of understanding on the part of the person to whom they go to have medications prescribed. General practitioners will frequently tell women they cannot take an anti-depressant when they are breastfeeding and will prescribe an antibiotic. There are publications on this, of which the most notable are by Hale and pharmacologists working in this whole area, including Wendy Jones. These studies are available to anybody with access to Google. One can look up what types of risks are associated with using what are deemed to be L1, L2, L3 and L4 medications during lactation. Obviously, L4 medications are not to be taken during lactation.

Women who are suffering from post-natal depression are highlighted in particular. Those who are lucky enough to live in Dublin will report that the information they may have received from a perinatal psychiatrist or the hospital they are attending differs from the information they are receiving from their general practitioner. This is an issue in and of itself and probably one which requires training or greater awareness. There is some type of gap in this respect.

I will allude to some of the comments Dr. Boylan made about home birth. The national maternity strategy steering committee heard from many experts in this field, both nationally and internationally, and evaluated all of their evidence. As a result of this evidence, the committee made the recommendation that home birth is a viable option and setting for low risk women. One of the studies that was discussed in detail, the birthplace study, looked at more than 63,000 births in the United Kingdom. The study revealed that for women who are having a second or subsequent child in a straightforward normal pregnancy, home birth was as safe as birth in an alongside birth centre and this is as safe as an independent free-standing birth centre, which, in turn, is as safe as an obstetric unit for such births. The caveat was that for women who are experiencing their first pregnancy, there was a very small but significant increase in perinatal poor outcome with a home birth, but not with an alongside midwifery led unit or a free-standing birth centre. That is the research that we acted upon and to which Dr. Boylan may have been referring.

On the question regarding home birth and breastfeeding, particular groups of women choose home birth and these women will do extensive research in arriving at their decision because this is not an option we offer to women as an obvious choice. When women pronounce themselves pregnant at the general practitioner they are not automatically told they can have a home birth. As such, this an option they must research themselves. Someone who does significant research will find what is best for themselves and their baby, which includes breastfeeding. However, the key issue is the continuity of care that a woman will receive from a small number of midwives or perhaps one midwife whom she will see throughout the pregnancy and with whom she will talk for perhaps one or two hours at every antenatal visit. Home birth visits involve perhaps two or three hours of speaking to somebody antenatally at every antenatal appointment. Unfortunately, women do not get this in hospital, where they will have a five minute or ten minute visit if they are lucky. Given the absence of continuity of care, except in the case of women who choose to go private, a few minutes of every appointment will involve the woman repeating exactly the same explanation as she gave at her previous appointment because the person she will see will not be the same person she saw on the previous visit. In terms of breastfeeding rates for home birth, therefore, I underline that it is the continuity of care that women receive which enables the higher rate.

On mastership, while the strategy recommended a mastership model for all hospitals, it added a caveat. My two colleagues on my right may have assumed that the master would be an obstetrician. However, the strategy referred to the master being a clinician, who would not necessarily be an obstetrician and could potentially be a midwife. The post would be available to either profession and it needs to be acknowledged that it would not necessarily be a particular type of clinician. It could be one of several clinicians.

There are two female masters in the Dublin maternity hospitals and they both like the term "master". The majority of women do not like the term, however, because if there is a master, there must be a few slaves. Nobody wants to be viewed in any way as being in a position where someone else is his or her master or has autonomy over them. While we wholeheartedly agree with the concept of mastership, we have some difficulty with the lexicology.

I will not comment on folic acid, the adverse events and the lack of screening because these issues have been covered. Health promotion is an area that needs to be heavily resourced as it has been subjected to budgetary cuts. This needs to be investigated and examined.

We were asked about public health nurses and midwifery. Until recently, it was necessary to be a midwife or at least have an 18-month diploma of midwifery in addition to nursing to be a public health nurse. This has not been a requirement for five or six years. If there are older public health nurses working in the community, they will have midwifery, whereas younger, more recently trained public health nurses will not have midwifery. That was a decision taken by the profession and one I do not believe has necessarily served well the women who are being taken care of by public health nurses immediately post-partum. Obviously, public health nurses have an extensive remit and it is not exclusively focused on women who have just had babies. However, this is an unfortunate development as far as women are concerned.

We were asked about mothers being separated from their babies and the differences in public and private care in that respect. The ratio of midwives to women they are caring for in a post-partum scenario will be much lower in private care, which means the women will receive more one to one care than they would if they were in a public setting. However, our experience has been that, whereas the public-private divide can be quite marked in other aspects of maternity services, in terms of women separated from babies who are in a neonatal intensive care unit, NICU, being encouraged to express, I do not believe the divide is especially marked in terms of public or private care. All women are encouraged to express if their babies are in a NICU. The variation is between units and not necessarily between private and public. For example, Limerick general has produced astounding research associated with lack of infection and secondary infections in babies in the NICU because all the babies get breast milk.

A lactation consultation in the National Maternity Hospital has just finished a masters study looking at ensuring that every baby in the NICU received breast milk. One of the issues is Ireland does not have a breast milk bank. There is one in Northern Ireland, which will be in a different jurisdiction following Brexit. This is a random issue that Brexit might affect. I do not know what the effect of that will be. Moving forward, we in the South should have the capacity for milk banks, and not just one, in order that women who genuinely have great difficulty in giving their babies breast milk have another option. Regional milk banks have been suggested. Currently, because of the lack of milk banks in Ireland, there is informal milk sharing among women through a website, *Human Milk 4 Human Babies*. Women visit that site because they need supplementary breast milk. They do not want to give artificial milk but they are unable to access the milk bank in the North.

I was asked if we have home births, midwifery units and domino births, how we can be sure the babies and mothers will be safe if they are scanned. There are strict criteria for acceptance on to a home birth programme or a midwifery-led unit or a domino service. They include a scan and constant screening antenatally. The NPEC has produced an audit of each home birth for the years, 2012 to 2014. The 2015 audit is due. The audits show that the majority of women who do not get to have home births have been screened out antenatally. They planned a home birth, signed up and fulfilled all the criteria at 12, 13, 14 and 15 weeks but as time went on, did not continue to fulfil the safety criteria. The majority of women are removed from a home birth service antenatally before they go into labour.

I refer to perinatal mental health and mother and baby units. I sit on a specialist perinatal mental health committee that is examining how these issues can be addressed and it will publish a report soon. One of the issues the committee has come up against is the administrative

zones for mental health services are different from those for maternity service provision and, therefore, where there is a crossover of two services that need to interleave, there is an issue. For example, Wexford and Waterford hospitals are in the same mental health administrative area but they are in different maternity hospital groups although they are close geographically. That will cause difficulty in determining how care can be allocated and developed. Mother and baby units are needed. Currently, women who suffer from perinatal mental health issues such as depression or extreme conditions such as post-traumatic stress disorder, bipolar disease or psychoses have to be admitted into normal adult mental health facilities that are available in the community. That means they are separated from their babies. Ms Kerans will comment further on that. With regard to the information women with perinatal mental health issues receive- it is not just about breastfeeding - they are reluctant to indicate that they have them because they are frightened that their baby will be taken from them. They are afraid of Tusla getting involved. That is a known factor in the underestimation of the number with perinatal mental health problems.

I am not sure what the Deputy was referring to regarding data protection but we are implementing a new electronic health record. Hopefully, that will be seen to be useful for women. In other countries, for example, Germany, there is what is called the *Mutterpass*. Everything the woman encounters during her pregnancy journey is inputted into this electronic chip health record, even if she attends different settings or health care professionals. Local community health care provision is also recorded. All that is put on the one card and everything is collated in that way.

Regarding the next steps for implementation, the most important is to have an implementation committee appointed and an implementation plan. My assumption is the strategy forms part of that.

Deputy Durkan asked what are the main areas. He referred to the tragedies we have witnessed. The media are a funny beast. They pick up certain issues and they want to run with them but they are not necessarily the issues or the outcomes that we want highlighted. Being a journalist means highlighting anything that will get your newspaper read and more publicity. We have heard of the deaths of both mothers and babies but what is more important to me in the work I do is the day-to-day tragedies that people feel that they face. These tragedies would never make a media headline because they are not deemed to be that important. There are issues that affect women hour to hour. Professor Kenny referred to a mother not being able to hold her baby when her baby was dying. These tragedies are of no interest to journalists because they will not make the headlines. Women and their families face these tragedies, whether they involve a death. In general, they do not relate to death; they relate to the way they have been treated or what has been said to them or available choices. Women experience such tragedies in every one of Dublin's maternity hospitals, which have a mastership programme. We know because they tell us that every day. While I agree with a clinician being in charge of a hospital, I do not say that only governance issues will stop those day-to-day tragedies. There are issues associated with postnatal physical and emotional care that are important, which we have highlighted. There are issues associated with continuity of care and different care models. Women have little choice in the way they are cared for and who cares for them in Ireland. It is incredible that our country has so little choice for women, especially in rural areas.

A number of the initiatives that have resulted from some of the tragedies, for example, the bereavement standards, have been important. Couples who experienced tragic outcomes with their babies highlighted their issues and the State took them on board. We have fabulous be-

reavement standards, which, hopefully, will be implemented and audited.

Deputy Bernard J. Durkan: I do not wish to go into individual tragic circumstances but a number come to mind. Inevitably, moneys are spent on the defence of court cases. In my comments, I was trying to balance the hospital needs, the service needs and the maternity needs initially against the cost of having to defend the tragic outcomes in court. If €1 million is to be spent in the courts or in the hospital, which is the better option for the patient and which is the better option for the service? We need to be clear about that. This is hugely important. In one or two of the cases that come to mind, there might have been an initial failure as well. I do not know; I was not there. However, those issues need to be identified. There are costs associated with both. If there is a deficiency in the delivery of the services in the hospital that is not associated with funding, we need to know about that as well. Either way, the State ends up paying and the service ends up getting the bad publicity.

Deputy Kate O'Connell: In terms of the outcomes for families in cases where money has been paid for a catastrophic incident at birth who have to deal with a child with a defect for the rest of their lives that was caused during birth, no money would compensate them.

Dr. Krysia Lynch: One of the issues is that we have to ensure as a nation that we are providing the safest possible care for all women and their babies who enter into our maternity services. One of the things we heard from the experts when we were in the strategy deliberations was that we are not currently doing that because we are not providing the various models of care that are most suited to the women that are presenting. That is part of the problem.

In terms of paying money out in the courts, it is very difficult, as Deputy O'Connell has said, to put a price on somebody's life. The brutal economics of health care are such that one is always going to have to make a decision for one very rare case versus the vast majority of cases. I certainly would not like to be making those decisions but they do have to be made.

Open disclosure is very pertinent to a lot of these discussions. Moving towards an environment of open disclosure and perhaps moving towards an environment when we know there is a very unfortunate and tragic outcome that we know how much is required in terms of monetary funds to assist the family during the baby's lifetime, and that also we know what the potential prognosis is for the baby. Sometimes we do not know and that is why we end up having large payments because it is very difficult to identify whether a baby will live for 60 years or only live for five years. One has to make the provision in the courts that the baby will live for 60 years and that it will be provided for. That is perhaps a little outside the remit of today's meeting but it is something that needs to be looked at.

Ms Breda Kerans: In terms of the various tragedies that have occurred, a number of key issues were highlighted that come under the heading of communications. My perspective is that of a service user. When care is transferred, whether it is between clinicians in the same hospital between different units, if communication fails between service users and the clinician or between primary care and the hospital anywhere along the line it is a huge risk factor and there can potentially be catastrophic outcomes. In many cases the communications failure will not lead to any adverse outcome because one will, essentially, get away with it as things go along as normal. However, if at any level that communication fails in terms of a really important event, for example, in the case of the maternal death in Galway one of the issues was laboratory results not being communicated in a timely fashion. That was one element of the situation. Communications are an issue across the board as they are also implicated in adverse emotional outcomes for families in terms of information being communicated in an inappropriate manner,

at an inappropriate time or by a person not trained to give the information. That was one issue that was highlighted.

The dependency on agency staffing or staff whose training level is not up to date in key areas such as neonatal resuscitation, came up as another issue. Agency staff are not necessarily familiar with the hospital setting they are in, which also plays a part. If one has come to work in a hospital for the first time and a major event happens one does not necessarily know who to ring, where the theatre is or other important bits of information. Training at all levels has been highlighted for NCHDs and midwifery training as well as key skills that need to be up to date in order to deliver safe health care.

The issue of rural units that do not have scanning and other facilities was raised. Dr. Lynch and Dr. Boylan already covered home births. In terms of the smaller units that currently operate, it is important to weigh up travel distances in terms of safety outcomes and babies born before they arrive at the hospital and the risk factors that exist, in particular given that we do not have a lot of anomaly scanning in those units we do not know who will be born at the side of the road. It is far worse to be born at the side of a road than to be born in a unit no matter how good the unit is. That must also be taken into account.

In terms of perinatal mental health units, Dr. Boylan mentioned that we do not have any mother and baby units. He is correct. Women are separated from babies. In some of the regional units where there are psychiatric units on a hospital site it is a little less traumatic for the family because at least the mother and baby are on the same site and they can visit each other, but where that is not the case, which in effect is in most hospitals, it means there is a distance between the mother and the baby which is incredible in this day and age. One must take into account the psychological impact on the mother and infant development in the long term. Bonding between the mother and baby is compromised in such situations. That is certainly not best practice internationally.

Dr. Lynch mentioned that there is a big issue around mental health administrative zones and maternity zones. They do not measure up at all. The difficulty between matching up the zone for the maternity unit and the women attending there and the community mental health zone and the communication between them is something that was highlighted on the perinatal mental health group in Galway as being another risk factor. I think everything else has been covered. I do not wish to hold up the meeting.

Chairman: There is a little frisson of political uncertainty around this morning so members might be distracted.

Deputy Bernard J. Durkan: The situation has been greatly exaggerated, to paraphrase the words of Mark Twain.

Chairman: I get a sense that members are anxious to go.

Ms Breda Kerans: Could I add one point? You asked what we could do, Chairman. One thing I think is very important that we are not doing, which is happening in many other jurisdictions, is capturing the service user experience in a meaningful manner. We have *ad hoc* patient satisfaction surveys, which are a very different thing. It is happening in countries such as Canada and the UK and we have linked various surveys and how they happen in our document. They are particularly good examples. The reason I feel that is very important from a safety aspect is that service users navigate the entire service from beginning to end. Dr. Lynch mentioned that

earlier. I am a founding members of AIMS Ireland and we founded the organisation ten years ago. One of the things we found at the outset was that women were highlighting issues to us that we were not hearing from maternity units as being a factor, yet when we had the tragedies and they were investigated the issues women highlighted to us were seen to be causative factors. Capturing the service user experience can highlight problems at an earlier phase and that is a very important part of developing a safer service.

Chairman: I will go back to the issue of autonomy in relation to the management of maternity units. It is an issue that has been brought up on many occasions in regard to all our hospital services, that there is a problem with autonomy, certainly at clinical level, within hospital services. There are a number of members present who are also members of the Committee on the Future of Healthcare and we are trying to grapple with how we can change our health service to make it more efficient and more effective. Apart from governance, which is Nos. 1, 2, 3 and 4, do the witnesses have any other game changers or triggers that will change the health service to become a better one?

Dr. Peter Boylan: There are a few things, and one is better availability of diagnostics for GPs. It is ludicrous that a GP has to refer a patient to a hospital to an outpatient clinic to assess whether they need a scan, MRI or other test. They are seen by a junior doctor and the process can take months. If GPs had direct access to better diagnostic facilities, as they do in other countries, that would be enormously helpful.

There is a capacity issue. There are clearly not enough beds in the hospital system. Staffing is another major issue. One thing that could certainly be improved is the access to diagnostics for GPs working in the community. If the committee would like, the institute can prepare a paper and appear before the Committee on the Future of Healthcare.

Chairman: If the institute would prepare a paper, it would be wonderful. I am not sure if that committee has space. It is going to produce its report at the end of April. I thank the witness for his insights.

Senator Colm Burke: It would be helpful if the paper was presented to this committee so that it would be on the record. This committee could then correspond with the Department and the HSE on the matter. It is a very constructive suggestion and it should not be passed over. This committee would very much appreciate if a paper were prepared.

Deputy Kate O'Connell: In terms of the success of the national cancer strategy, this committee is exploring universal access from the start. I am told that in Cork there is no major benefit to being a private patient. That is obviously positive. My sister had twins in the unit there. I am a member of the Committee on the Future of Healthcare, as is the Chairman, and one of the focus points of that committee is that the least we can do is give people the standard of service that they deserve at the start of life.

Chairman: On behalf of the committee, I thank Professor Louise Kenny, Dr. Peter Boylan, Dr. Krysia Lynch and Ms Breda Kerans, for giving evidence on the national maternity strategy.

As there is no other business, the joint committee is adjourned until next Wednesday when the Minister and the HSE will be in for the quarterly meeting.

The joint committee adjourned at 11.30 a.m. until 1.30 p.m. on Wednesday, 22 February 2017.