

# Annual Report 2018



National  
Women & Infants  
Health Programme

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## Message from the National Programme Director

I am happy to share the HSE National Women and Infants Health Programme's third Annual Report on the implementation of the "National Maternity Strategy – Creating a Better Future Together".

Whilst 2017 saw the establishment of the Programme and the National Maternity Strategy Implementation Plan; 2018 was a significant year for the enhancement of maternity services. This Report outlines some of the key developments made by the Programme and our colleagues at national and local level during 2018.

The primary focus of the Programme in 2018 was the implementation of the Model of the Care and a continued focus on quality and safety. This work was enabled and supported by the Department of Health by means of the allocation of an additional €4.55m developmental funding in 2018. This additional resource allowed the Programme to continue its investment in each of the Maternity Networks so as to create an equitable maternity service nationally.

**Kilian McGrane**  
**Director, HSE National Women and Infants Health Programme**

# Part 1 – Background

## 1.1 Overview

In 2016, a robust policy and strategic framework for the development and delivery of maternity services was established in Ireland with the launch of the National Maternity Strategy – *Creating a Better Future Together, 2016-2026* in January 2016, the *National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death* in August of that year, followed by the Health Information and Quality Authority's *Safer Better Health Standards for Maternity Services* in December 2016.

In order to ensure a co-ordinated and focused approach to the work required to ensure that these policies were implemented and overseen at national level in a structured and programmatic manner, the HSE, with the support of the Department of Health, created the National Women and Infants Health Programme. In driving these policies, the Programme is responsible for the enhancement of maternity services, benign gynaecology services and neonatal care. This work entails working closely and collaboratively with colleagues across operations and strategic planning in both acute and community care settings.

In 2018, the Programme continued to build on its work commenced in 2017 using the four strategic priorities from the National Maternity Strategy as the framework for its work. These are as follows:

- A health and wellbeing approach;
- Access to safe, high quality nationally consistent, women centred care;
- Providing women with informed choice as to their pathway of care;
- Ensuring the appropriate resourcing, governance and leadership for maternity services.

## 1.2 Our Objective

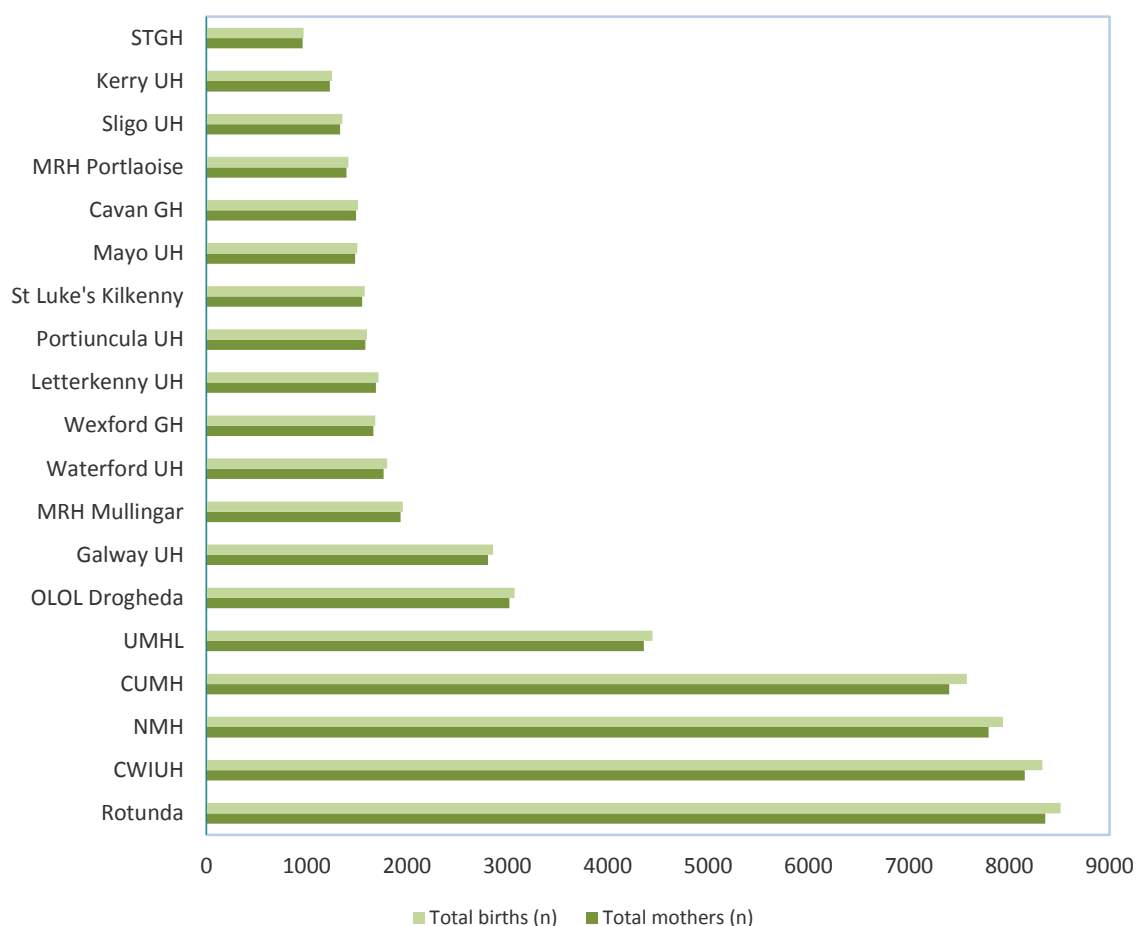
A key objective of the Programme in 2018 was to standardise practice in maternity services, building on and using the knowledge gained through engagements and meetings with colleagues across the 19 maternity hospitals/units in 2017. Standardised and equitable care nationally across all care settings is a fundamental focus of the Programme. This was done acknowledging that the vast majority of maternity services are currently delivered within an acute setting, but that overtime in line with the National Maternity Strategy, more care will be delivered to women in the community.

With regular engagement, we continue to build a strong working relationship with colleagues in the Department of Health and various stakeholders (see appendix 2). This continued engagement has been critical in order for the Programme to best understand the changing landscape and determine the most appropriate way to implement the National Maternity Strategy.

### 1.3 The Maternity Hospitals/Units

All 19 maternity hospitals/units are part of the six hospital groups (appendix 1). There are four standalone maternity hospitals and 15 maternity units located within general hospitals.

There is significant variation between each of the 19 maternity hospital/units with a substantial range in the number of births per hospital/unit. The number of live births and stillbirths weighing  $\geq 500\text{g}$  for 2018 is set out in the chart below. Also provided is the number of women delivering a baby weighing  $\geq 500\text{g}$  in 2018.



**Figure 1: Total number of live births and stillbirths weighing  $\geq 500\text{g}$  for 2018, total number of women delivering a baby weighing  $\geq 500\text{g}$  in 2018**

Source: IMIS 2018 Report, published (June 2019)

Infrastructural differences exist across all 19 maternity hospitals/units, with the majority of the 19 maternity hospitals/units requiring investment to meet current hospital accommodation standards. It is acknowledged that the four standalone hospitals are planned to co-locate with an adult teaching hospital.

#### 1.4 The Team

The National Women and Infants Health Programme expanded its team in 2018 with the appointment of two General Managers in the latter half of 2018. The Programme in 2018 from within its core team had available to it medical obstetric and gynaecology, director of midwifery and senior executive expertise, supported by quality and risk, project management and administrative personnel. This work of the Programme and its core team was further supported and contributed to at national level by a range of additional personnel and teams including the HSE's National Clinical Programme for Obstetrics & Gynaecology, National Clinical Programme for Paediatrics and Neonatology, the Nurture Programme, the Bereavement Standards Working Group, the National Breastfeeding Programme and the HSE's Mental Health Programme.

In presenting this Report, the Programme readily acknowledges with thanks the work and contributions made by these work programmes in driving the development of better, safer maternity services in Ireland.

#### 1.5 Keys Areas of Work in 2018

As set out previously, whilst the primary focus of the Programme is the enhancement of maternity services, benign gynaecology services and neonatal care, the concentration of expertise and resources in an area primarily concerned with women's health related services, has resulted in additional projects and work streams in the area of women's health being allocated to the Programme since its inception.

Whilst not within the original remit of the Programme, the availability of a focused team with the relevant clinical expertise has enabled the HSE to allocate these work streams to a team that heretofore would not have been readily available at national level. Such areas include the HSE's response to the use of uro-gynaecological mesh in surgical procedures, planning and implementation of a termination of pregnancy service and the model of care for assisted human reproduction.

Therefore appreciating the broad remit of the Programme in 2018, the following areas were prioritised within 2018 and were aligned with HSE National Service Plan 2018:

## Health and Wellbeing

- Nurture Programme
- National Plan for Benign Gynaecology
- Promoting Breastfeeding in Ireland
- Perinatal Mental Health Services;
- Smoking Cessation;
- National Standards for Bereavement Care

## Quality and Safety

- Anomaly Scanning
- Intrapartum Fetal Heart Rate Monitoring Guidelines
- Irish Maternity Early Warning System Guideline
- Irish Maternity Indicator System
- Publication of a Neonatal Therapeutic Hypothermia Report
- Learning Notices
- Maternity Event Review Tool

## Choice

- Model of Care – Supported Care Pathway
- NCEC Childbirth Guidelines
- Maternal and Newborn Clinical Management System

## Governance and Accountability

- Maternity Patient Safety Statements
- Maternity Networks
- Serious Incident Management Forums
- Support Professionals and Promote Inclusiveness
- Funding
- Parliamentary Affairs;

## Additional Areas of Activity

- The Use of Uro-gynaecological Mesh in Surgical Procedures
- Termination of Pregnancy Services
- Model of Care for Assisted Human Reproduction
- National Cervical Screening Programme



## Part 2: Health and Wellbeing

### 2.1 Nurture Programme

The vision of the Nurture Programme is to improve outcomes for all children and families from conception to the child's 3<sup>rd</sup> birthday through the provision of universal information and professional supports. The programme is being implemented through six implementation teams, with the Antenatal to Postnatal team leading on outputs relevant to pregnancy and preparation for parenthood.

The work of the team in 2018 included developing antenatal education standards, development and publication of the My Pregnancy Book and development of the mychild.ie website. Underpinning all of this work was consultation with a wide range of key stakeholders through workshops, interviews, surveys, and focus groups. Set out below is a brief overview of each key area:

- **Developing Antenatal Education Standards**

Standards for antenatal education were highlighted as a priority by the programme and further informed by the HIQA consultation of Maternity Standards. Commencing in 2017, the team developed a set of standards which involved reviewing international standards and their formats, followed by an iterative process of developing, reviewing and editing standards. In January 2018, a facilitated workshop was held with over 100 antenatal education providers from across Ireland to gather their feedback on the initial set of standards and their suggestions for implementation. Feedback was used to develop a final set of standards. This was the first time maternity, community and private antenatal practitioners were given the opportunity to meet and be involved in a national conversation about antenatal education.

To get insight into how the proposed standards align with current antenatal education practices, and to inform the future implementation of the standards, the team finalised two further consultations in 2018:

- With all managers (or representatives) of midwifery and community antenatal services in Ireland, and 116 practitioners, including private providers, and
- With over 3,000 parents through an online Nurture survey.

These consultations explored how antenatal education is delivered in Ireland and how it is experienced by parents. Reports on these consultations are available. Practitioners were

supportive of the idea of antenatal education standards, and inconsistent experiences by parents emphasised the need for them.

The most significant finding from all consultations was the need to provide an educational response to current challenges in accessing training and on-going supports for practitioners delivering antenatal education in Ireland. Guidance was sought on developing an antenatal education curriculum from Mary Nolan, Professor of Perinatal Education, based on the UK experience with the *Birth and Beyond* programme. Development of a revised training curriculum for providers is in progress which will complement the 6 day Programme which is currently only available in Cork.

- **My Pregnancy Book**

The 'My Pregnancy' book was launched as part of a suite of 'My Child' resources by the Minister for Health Simon Harris on 6<sup>th</sup> December 2018. This is the first comprehensive universally available pregnancy information book available free of charge to all expectant parents in Ireland and is NALA approved.

The My Pregnancy book was developed via a review of international and national antenatal information books and materials and extensively drafting by the Antenatal to Postnatal team and supporting subject matter experts. The type and format of the content was informed by consultation with over 3,000 parents and the layout and design was tested with diverse groups of parents.

- **Web content on mychild.ie**

In parallel with the development of 'My Pregnancy' book, the team collated and drafted relevant content for the new mychild.ie website launched in December 2018, which provides accessible evidence-based information for parents. The pregnancy information section has been developed by the team with additional specialist expertise provided by clinicians in collaboration with the NWIHP.

Priorities for 2019 for the Nurture Programme include finalising the antenatal education standards, developing an antenatal education curriculum for practitioners, continuing to develop the mychild.ie website and ensuring the sustainability of outputs with NWIHP.

## 2.2 National Plan for Benign Gynaecology

Within the area of obstetrics and gynaecology, it was identified by the Programme that the area of benign gynaecology was one in which services were poorly developed, waiting lists for both outpatient and day-case/inpatient were growing and there existed no coherent plan

or model for their development. In the context of this service serving half the adult population, the demand for this service as recorded in national waiting lists, represents one of the key areas of unmet need in the health service. Further pressure in this service area was also identified in 2018 on foot of the challenges on-going within the Cervical Check Programme and the resultant increase in referrals from primary care practitioners within an increasingly risk-averse environment.

The development of a national plan in this area was commenced by the Programme in late 2018, with a baseline exercise being undertaken to determine the different models of care in place for the provision of benign gynaecology services, particularly with reference to ambulatory clinics and services. New and innovative waiting list initiatives underway locally were also reviewed and engaged with, so as to establish proof-of-concept parameters and gain from learning made.

The plan under development by the Programme will examine the capacity of and demand on benign gynaecology services in Ireland and identify ways that access to care can be increased in an equitable and cost effective manner. It is intended that this plan will be completed in 2019 and will be submitted to the HSE leadership team and the Department of Health.

### 2.3 Promoting Breastfeeding in Ireland

At the start of 2018, Siobhan Hourigan stepped down as the National Breastfeeding Co-ordinator and was replaced by Laura McHugh. Assistant National Breastfeeding Co-ordinator, Rebecca O'Donovan left her position at the end of 2018. The Programme would like to thank both Siobhan and Rebecca for their contribution made in promoting breastfeeding in Ireland and thank them for their hard work.

A range of different work programmes and work streams were undertaken in the area of breastfeeding in the HSE in 2018. A high level of overview of these areas is provided below:

- **Baby Friendly Initiative**

The Programme provides governance for the revised model of the Baby Friendly Initiative (BFI) in Ireland. In 2018, a national BFI standards project group was formed to develop revised BFI standards and assessment tools and provide expert input in informing a revised approach for implementation. An interim self-audit tool for maternity services was developed. UNICEF UK which is responsible for BFHI facilitated audit training for 41 clinical staff. This audit tool was deployed at the end of 2018, and findings from same will inform the progression of work in 2019.

- **Job Specification**

A job specification for specialist lactation consultant posts in maternity hospitals/units was developed. Feedback on this specification was sought and received from maternity hospitals/units and the Office of Nursing and Midwifery Services Director (ONMSD).

- **Breastfeeding Training & Skills Development**

Breastfeeding training and education seminars were facilitated by many maternity services throughout 2018. The Nurture Programme is providing financial support for the development of a suite of breastfeeding training programmes and a framework for overall delivery. The training consists of three elements: two online e-learning modules (Units 1 and 2) launched in October 2018 and face-to-face skills development. From the launch in October until the end of 2018, 418 HSE staff had completed Unit 1 and 388 staff had completed Unit 2.

- **Health Service Policies and Practices**

The updated Infant Feeding Policy for Maternity and Neonatal Services was approved at the end of 2018 with expert input and feedback from consultation with the Director of Midwifery, Clinical Programmes, the Chief Officer Group, Neonatal Dieticians & Paediatric & Neonatal Clinical Advisory Group & Obstetrics and Gynaecology Clinical Advisory Group.

The HSE marketing of breast milk substitutes and HSE workplace breastfeeding policies were both progressed following consultation with various groups and are expected for implementation in 2019.

- **Supports at all stages of Breastfeeding Continuum through Social marketing, Support and Advocacy**

Input was given to developing the 'My Pregnancy Book', standards for antenatal education, developing key messages for parents and professionals and providing relevant information for the HSE's new child health website mychild.ie.

There were 129 events around the country as part of National Breastfeeding Week 2018, in which many maternity services staff took place in media events. Limerick City and County Council, supported by Healthy Ireland HSE, launched the "We're Breastfeeding Friendly" campaign at the start of National Breastfeeding Week.

- **Research, Monitoring and Evaluation.**

The Programme, through partnering with the work of the Irish Maternity Indicator system (IMIS), has agreed to enhance the current breastfeeding data available to the programme

from maternity hospitals/units in order to monitor progress. It was agreed to introduce the following breastfeeding metrics into IMIS in 2019; Breastfeeding initiation and Breastfeeding on discharge (exclusive and non-exclusive). Having access to such timely data will be a huge benefit to monitoring and understanding breastfeeding trends in Ireland. Breastfeeding Initiation is set as a HSE target in 2019 (64%).

Priorities for 2019 in the area of breastfeeding include additional breastfeeding support posts for maternity and community services (funding dependant); approval of HSE Policy on the marketing of Breast milk substitutes & HSE Breastfeeding in the workplace policy; progress the Baby Friendly Initiative; progress skills based aspect of the blended breastfeeding training programme; and establish a breastfeeding stakeholder forum.

## 2.4 Perinatal Mental Health

The HSE's Specialist Perinatal Mental Health Services Model of Care was launched in late November 2017. Its implementation began in 2018 overseen by the clinical lead and programme manager through the National Perinatal Implementation and Oversight Group (NPIOG). Specialist Perinatal Mental Health Multidisciplinary Teams are being recruited for the maternity hospital/service hub in each of the six Hospital Groups/Maternity Networks. The additional consultant posts required in the hub sites for these teams are being funded via the National Clinical Programme for Mental Health, whilst the required specialist perinatal mental health midwives for all 19 maternity services are being funded via the Programme.

Three of the teams were operational by quarter 4 2018 with a fourth perinatal psychiatrist identified to start early 2019.

This implementation of the Model includes the recruitment of a mental health midwife for each of the maternity hospitals/units with two mental health midwives for the four larger maternity hospitals; those with approximately 8,000 deliveries per annum. The specialist teams and mental health midwives work jointly to ensure all women attending the maternity service will have information on positive mental health, standard questions on mental health as well as physical health are routinely asked of each woman attending both booking and review clinics. They also provide a triage system so that women with mental health problems are assessed by the appropriate team member; that is a mental health midwife for milder problems, with women who have more severe problems being seen by the specialist team in the 'hub' maternity hospitals and liaison psychiatry team in the 'spoke' maternity services in each maternity network. Between May and December of this year, approximately **2,000** patient contacts were made with one quarter of these women seen as inpatients in maternity hospitals. The most prominent age group are those between 30-39 years. Psycho-education

was the most common intervention used amongst **1,037** contacts and a further **960** women received individual therapy. During this time, **544** women were seen by two or more of the SPMHS multidisciplinary team with **320** women with were seen by the mental health midwife only.

## 2.5 Smoking Cessation

Providing support to women who smoke before, during, and after pregnancy is an important aspect regarding the Health and Wellbeing of women, supporting the implementation of the Healthy Ireland Framework (2013-2025).

Within 2018, the Programme worked with the HSE Health and Wellbeing Division with a view to designing and introducing a pilot smoking cessation initiative in one of the Maternity Networks in 2019. It is anticipated that the pilot will be driven by one whole time equivalent clinical midwife specialist as funded by the Programme. The initiative will aim to identify and refer women who smoke at the time of their booking visit to the specialist midwife for appropriate care and follow up. It is being planned that this initiative will be launched during the course of 2019.

## 2.6 National Standards for Bereavement Care

A specific focus to the Health and Wellbeing chapter of the National Maternity Strategy Implementation Plan was the improvement of support services for women who have experienced the loss of a baby. This was initiated through the launch of the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death across all 19 maternity units, published in August 2016.

Dr Keelin O'Donoghue, Consultant Obstetrician & Gynaecologist in CUMH was appointed as National Implementation Lead for the Standards whilst Ms. Ríona Cotter was appointed as programme manager for same in March 2017. The implementation programme commenced in March 2017 and is facilitated by a 14 member National Implementation Group (NIG) made up of a multi- disciplinary team of health care professionals who have experience and expertise in the area of pregnancy loss and perinatal death. The NIG continued to meet monthly in 2018.

A range of different work programmes and work streams were undertaken in the area of bereavement care in the HSE in 2018. A high level of overview of these areas is provided below:

- **Unit Assessments**

From May to August of 2017 all 19 maternity units were visited by Dr O'Donoghue and Ríona Cotter. An assessment was undertaken of each unit's bereavement care against the Standards. Individual feedback from the assessments was given to each unit with recommendations for changes needed. Each hospital was requested to give a quality improvement plan to the National Implementation Group of plans for improvements and the implementation of the recommendations of what additional supports are required to implement the standards.

In 2018 each unit was requested to give a progress report on their original quality improvement plan and outline new developments in their bereavement service.

- **Policies & Procedures**

Drafts of care pathways for different types of pregnancy loss were finalised following input from the NIG and the parents' forum. They will be published in 2019.

A draft document on Perinatal Bereavement Standards was developed in 2018. It is currently being reviewed by members of the NIG and colleagues involved in education. It will also be published in 2019. Members of the NIG attended a one-day workshop called Dealing with Loss in Maternity Settings which is based on The National Standards. This workshop was facilitated by the Irish Hospice Foundation. The NIG has recommended that this programme be offered to all staff in all 19 Maternity hospitals.

As part of the National Clinical Programme for Paediatrics and Neonatology, the National Neonatal/Perinatal Palliative Care Group developed a pathway on perinatal palliative care, which will be also be published in 2019.

- **Referrals & Integration**

Last year this work stream identified all the support/voluntary organisations who provide support to parents experiencing pregnancy and perinatal loss. Following on from these members of the NIG met with representatives of the larger organisations providing support to bereaved parents. All organisations expressed an interest in attending an education day facilitated by the NIG on bereavement care. To facilitate this a Delphi study was undertaken to explore what the education priorities of these groups were. Once the priorities were identified a one-day education programme was developed and offered to representatives from each group. The education day was held on December 1<sup>st</sup> in the Coombe Women and Infants University Hospital in Dublin. There were representatives from most of the large

organisations in attendance. This day was positively evaluated, with requests for further days to be run in 2019.

- **Parents' Forum**

A Parents' Forum was established and had its first meeting in November 2017. It is comprised of parents who have experienced the different types of pregnancy loss. The purpose of this forum is to ensure that bereaved parents views and opinions based on their experiences of pregnancy loss are represented in the implementation process. The parents contributed to the development of pathways with their input and feedback taken in to consideration. A member of the parents' forum also sits on the website development group described below.

- **Bereavement Specialist Midwife/Nurse Network**

A support network for this group was set up and met for the first time in September 2017. The purpose of this group is to act as both a support network and a professional network where experience and professional knowledge will be shared. The group met on a number of occasions in 2018. The NIG facilitated an education day for this group in Cork University Maternity Hospital in October 2018. The one-day programme was developed in response to requests from the group.

- **National Neonatal/Perinatal Palliative Care Group**

Both Dr O'Donoghue and Ríona Cotter sit are members of this group which is collaboratively looking at developing care pathways for families requiring perinatal palliative care, starting in the maternity hospital in the antenatal period and continuing on after the baby's birth and into the paediatric hospitals and the community.

- **Bereavement Clinical Midwife/Nurse Specialist**

Prior to the launch of the Standards in August 2016, the HSE made funds available to ensure that each maternity hospital had a bereavement CMS/CNS in post to support bereaved parents. When the Standards implementation commenced in March 2017, 10 Maternity hospitals had a CMS in post. By the end of 2017 a further three hospitals had recruited a CMS. With support from the Programme and at hospital level by the end of 2018, 18 of the 19 Maternity hospitals have recruited a bereavement CMS. It is envisaged that by the end of the implementation programme (March 2019) each hospital will have recruited a CMS.



- **Bereavement Forum**

The NIG hosted a Bereavement Forum on Croke Park Conference Centre on April 26<sup>th</sup>. This forum, attended by over 120 invited guests was attended by Mr Simon Harris, TD, Minister for Health. Mr Harris gave the opening address, followed by invited guests and Members of the NIG, who spoke about the progress of the implementation programme and bereavement care.

- **Website**

The development of a national website with content for Ireland was one of the tasks that the NIG was tasked with. A defined website is currently in development, with the support of the Irish Hospice Foundation who agreed to fund the development of the website and the maintenance of the website for a three year period. The purpose of the website will be to the sharing and dissemination of the documents produced by the NIG. This website is necessary to ensure that health care professionals delivering bereavement care have access to up to date, accurate information and advice. The information on the website will also be available for the public to access. The website will not provide a public forum to answer questions or facilitate open conversation. The website will be a repository for patient information with links to all of the support groups and parent advocacy groups working within the area of pregnancy loss. It will also be a repository for patient care documentation that staff can use e.g. patient information leaflets, direct admission cards etc.

- **Conferences**

Members of the NIG have spoken about bereavement care and the implementation of the Standards at various meetings and conferences throughout 2018. The NIG were well represented at the ISPID (The International Society for the Study and Prevention of Perinatal and Infant Death) conference in Glasgow in June with oral and poster presentations on various aspects of the Standards implementation.

- **Support & Advisory role**

The NIG has acted in a supportive and advisory role to a number of hospitals and individuals in the development and /or expansion of their bereavement services.

## Part 3: Quality and Safety

### 3.1 Anomaly Scanning

The implementation of the National Maternity Strategy will assure equitable access to standardised ultrasound services for all women which will accurately date the pregnancy and assess the foetus for ultrasound diagnosable anomalies. In early 2017, it was identified that only seven maternity hospitals/units offered all women access to anomaly scans at the 20 week gestation period. The management of this inequitable provision of service was identified as a key priority area for the Programme. Further to direct engagement with the hospital groups, the additional supports needed to meet the target that all women had access to anomaly scanning in all 19 units and services were identified.

Funding for 28 additional ultrasonographers was subsequently secured through the national service estimates process for 2018, with these posts allocated to individual maternity services based on the needs assessment undertaken. While challenges with the training and recruitment of ultrasonography staff have been identified through maternity network meetings as there is by necessity a lead in time with the training of additional personnel, significant and marked improvements in access to anomaly scanning were achieved in 2018. By the end of 2018, fourteen of the nineteen units were providing 100% access, with a 15<sup>th</sup> unit providing an anomaly scan at 32 weeks. The remainder of the units were providing anomaly scans based on clinical risk profiling and indications. Work in this area will continue in 2019, with 100% provision in all units being the target.

### 3.2 Revising the Intrapartum Fetal Heart Rate Monitoring Guidelines

A multidisciplinary working group was formed in June 2018 to revise the Intrapartum Fetal Heart Rate Monitoring (FHRM) Guideline. The Group met once monthly this year and anticipates publishing the guideline during the summer of 2019. This year has focused largely on the aims of the guideline; identifying questions to be answered within the document, as well as developing a rigorous methodology.

The Development Group are grateful for the time and commitment of two maternity service user advocates who are members of the Group. The Group will advance its work in 2019 making recommendations appropriate to fetal heart rate monitoring in the intrapartum period.

### 3.3 Revising the NCEC Irish Maternity Early Warning System Guideline

The National Clinical Programme for Obstetrics and Gynecology updates on the NCEC Guideline on the Irish Maternity Early Warning System (IMEWS) continued in 2018. A small

focus group, chaired by Prof Turner, was held in conjunction with the School of Nursing and Midwifery at Trinity College, Dublin to further develop the requirements for education and audit for the IMEWS (previously outlined in an IMEWS workshop day held in November 2017).

The HSE Quality Improvement Division assisted in developing Microsoft Excel audit tools and alignment of the audit tools was ensured through collaboration with the Nursing Midwifery Planning and Development. The Centre for Effective Services assisted in developing a logic model and implementation plan.

The Childbirth Guideline Development Group finalised and submitted the updated “Irish Maternity Early Warning System (IMEWS) V2.0” Guideline to the NCEC in September 2018. It is hoped that IMEWS 2.0 will be published in early 2019 to all maternity units and acute hospitals as well as the relevant professional bodies.

An IMEWS e-learning programme was developed between a small multidisciplinary team of content experts and a learning and development company who were awarded the tender for the work. This was funded by the Department of Health.

### 3.4 Irish Maternity Indicator System

The Irish Maternity Indicator System is a system which captures and presents key data metrics from all 19 maternity hospitals/unit each year. It encompasses a range of 33 multidisciplinary metrics, including hospital management activities, deliveries, serious obstetrics events, neonatal metrics and laboratory metrics. IMIS is a management instrument that serves several functions. It provides within-hospital tracking of monthly and annual data. It also provides national comparisons across all maternity units, allowing hospitals to benchmark themselves against national rates and over time. IMIS is an innovative and progressive tool in Ireland’s maternity services, paving the way for more timely scrutiny of hospital processes and outcomes for women and infants. Outlined below are the key stages involved in the 2018 Report and the main findings of same.

- **Process/timeline**

Data are collected within hospitals on a monthly basis. They are reviewed and signed off by hospital senior managers. The data for the first half of the year are sent to the National Clinical Programme for Obstetrics & Gynaecology in July/August and at year-end in February/March. Draft reports are sent to the hospitals in advance of finalising. Final reports are produced within two months of all final data being received. Workshops for QA Officers are held two/three times per annum.

- **Outputs**

The following interim and annual reports are produced each year - national report, individual hospital reports (19) and maternity network reports (6). The turnaround of reports is dependent on timely data returns from all 19 maternity hospitals/units.

- **Summary of Selected IMIS metrics in 2018**

- The number of babies born declined in 2018 (N=61,084), down by 1.3% since the previous year. The rate of multiple births was down on the previous year, at 18.3 per 1,000 women delivered.
- The rate of total perinatal deaths was 4.8 per 1,000 total births. Since IMIS began in 2014, the perinatal death rate has fallen by 20.7%.
- The rate of babies diagnosed with neonatal encephalopathy (NE) was 1.6 per 1,000 births. The rate of whole body neonatal cooling was 1.1 per 1,000 total births. Almost 6 in 10 of these babies (59.4%) were born at the four tertiary hospitals.
- The national rate of peripartum hysterectomy was 0.52 per 1,000 women delivered. The majority of these cases (65%) were treated at the four large maternity hospitals. Since IMIS began in 2014, the rate has increased by 42.1%. The national rate of severe perineal tears was 1.8%. This compares favourably with other European countries that range from 0.1% to 4.9% (Euro-Peristat 2016).
- Two cases of miscarriage misdiagnosis were reported in 2018.
- The rate of operative vaginal deliveries (OVD) was 15.0% in 2018. Since IMIS began in 2014, the rate of OVD has declined by 3.5%. As in previous years, there was substantial variation across hospitals, with OVD rates ranging from approximately 10% to 18% of women delivered. This has important implications for obstetric training.
- The national rate of inductions of labour (IoL) was 31.5% in 2018. Since 2014, the rate of IoL has increased by 6.5%. There are wide variations in induction rates across hospitals from approximately 20% to 37%.
- The national rate of Caesarean sections (CS) was 33.8%. Since 2014, the national rate of CS has increased by 13.9%. There was considerable variation across hospitals from approximately 26% to 42%.

- **Objectives for 2019**

IMIS was reviewed in 2018, with implementation of the revised version commencing in January 2019. Several metrics were replaced with new metrics, with the total number of metrics revised upwards to 40. Data definitions were amended/updated as required, and the

Robson Ten Group Classification System was incorporated to IMIS. Data from all hospitals for the first half of 2019 will be analysed to assess the progress of the revised IMIS.

### 3.5 Supporting the publication of the Neonatal Therapeutic Hypothermia Report

In 2018, the National Clinical Programme for Paediatrics & Neonatology (NCPN) in collaboration with the National Perinatal Epidemiology Centre (NPEC) published its first annual report on neonatal therapeutic hypothermia (TH) in Ireland. Previously, there had been no national overview of the current status and outcomes for TH in Ireland. This represented a dearth in knowledge available to clinicians, health managers and parents. The primary aim of this report is to present an overview and national statistics on TH in Ireland for the years 2016 and 2017.

This first national review of TH incorporated comprehensive anonymous baseline data on every infant in Ireland who underwent TH for the specified years. Data was collected retrospectively from inpatient medical records from all 19 maternity sites. Clinical details on maternal antenatal history, labour, delivery, infant characteristics, resuscitation, neurological assessment, transport details and 72 hour clinical course of TH were collected.

Key findings in the report were as follows;

- 140 infants were treated with TH suggesting that TH is provided to 1 in 900 infants born in Ireland.
- First time mothers accounted for 60% of the TH cohort.
- 34% of the TH cohort had their labour induced, compared to 29% of all deliveries in Ireland for 2016. In this report first time women were twice as likely to have their labour induced as compared with mothers who have previously given birth in the TH cohort.
- Caesarean section was the most common mode of delivery for all 140 infants accounting for 47% of deliveries. Of which 1.4% of mothers had an elective section, 47% of mothers in the TH cohort had an emergency Caesarean section pre-labour and 53% of mothers had an emergency Caesarean sections after the onset of labour.
- There were 18 (13%) documented cases of shoulder dystocia.
- 66% of infants had a cord p H  $\leq$  7.0.
- 79% of the infants had an Apgar score of 0-3 at 1 minute of life.
- 40% of the TH infants were born in a regional or local hospital of which 89% were transferred by the National Neonatal Transport Programme (NNTP).
- Data for Sarnat grading was incomplete in this report for both during TH and upon discharge.

- A specific placental pathology was presented in 83% of cases where a placental examination was completed.

There was an 88% survival rate amongst the infants who received TH. Of the infants who passed away, data was not collected on autopsy or post mortem results. As such, their cause of death is unknown.

It is the aim of NCPPN, NPEC and NWIHP to develop and implement a national TH electronic register for Ireland. A national e-register encompassing data on all cases of TH in Ireland will serve as a platform for identification of maternal, infant and clinical risk factors associated with the requirement for TH intervention; development of best practice guidelines and identification of trends over time.

Furthermore, a national e-register will facilitate benchmarking of TH in Ireland against international standards and therefore ensure continual quality improvement. NPEC will produce yearly reports based on the data collected. The e-register is currently in development and it is the objective of the NCPPN, NPEC and NWIHP to launch the e-register for use in 2020. In the interim all 2018 and 2019 data will be collected and reported upon.

### 3.6 Learning Notices

A Learning Notice is a communication document about a specific clinical issue, raised by corporate HSE, which needs to be brought to the attention of front line staff. The objective of these notices is to enable timely communication directly to front line service providers regarding specific issues and/or areas that have or are in the process of being reviewed and for which a change or modification in clinical management has been identified. These notices enable the service delivery system to respond rapidly to same, thereby ensuring any required changes in practices are implemented with minimal delay.

Learning notices are circulated electronically in accordance with governance structures with a request to cascade down to front line staff. Format may change from electronic to paper as computer access differs for staff at service level.

The National Women and Infants Health Programme (NWIHP) uses the learning notice platform as a means of communicating with front line staff in the 19 HSE public maternity hospitals/units from their corporate office base in Dublin. All notices are issued under the direction and governance of the clinical director of NWIHP and are in line with the principles and objectives of the National Maternity Strategy.

The source information resonates from various sources – changes to national policy, a HSE response to a patient cohort, adverse outcomes. In 2018, six learning notices and one safety notice were issued by the Programme concerning a range of issues and areas including neonatal hypoglycaemia, valproate, mesh, neonatal herpes simplex virus and CTG monitoring.

All notices can be viewed at: <https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/quality-and-safety/>

To ensure the effectiveness and reliability of Learning Notices NWIHP are undertaking a quality assurance piece in the form of a staff questionnaire and focus group. Ten maternity units have agreed to participate and questionnaires are being distributed in June 2019. It is envisioned that this piece will be complete at the beginning of Q4 2019.

### 3.7 Maternity Event Review Tool

In 2018 the Programme continued its work with the National Perinatal Epidemiology Centre on the Maternity Event Review Tool. The Maternity Event review tool (MERT), a standardised national intra partum event review tool, is a HSE web based electronic tool which facilitates the comprehensive and timely review of adverse intrapartum and perinatal events. It is anticipated MERT will aid the health service to review the circumstances preceding and surrounding such adverse events in a standardised way and produce a factual clinical report to be assessed by the Safety Incident Management Forum (SIMF) in each maternity network. The MERT aims to promote improvements in how reviews of maternity adverse events are conducted and responded to.

The MERT is to be used in conjunction with the HSE Incident Management Framework (IMF) for all cases of intra partum stillbirth, early neonatal death and hypoxic ischemic encephalopathy. As per the IMF classification system the MERT is a concise review with a desktop multi-facilitated multi-disciplinary team approach. Its degree of independence is very high with membership of SIMF including persons external to the hospital group. The timeframe for completion is 125 days from notification.

As outlined in both the National Standards for Safer and Better Maternity Services and the National Standards for the Conduct of Reviews of Patient Safety Incidents, the MERT aims to support and promote the safety of women and their babies as part of a wider National Women & Infants Health Programme (NWIHP) safety and quality framework. The information provided by the MERT tool will allow NWIHP and its partners to monitor and

learn from adverse maternity events and implement recommendations both at a local and national level.

All reviews being assessed using the MERT will need to be reported on the National Incident Management System first. When an adverse outcome occurs there is a statutory requirement to report to the States Claims Agency via the NIMS.

A Working Group has been assembled with key stakeholders to progress MERT. It is anticipated it will be ready to pilot in Q4 2019 and rollout to the 19 maternity units from Q1 2020.



## Part 4: Choice

### 4.1 Model of Care

The steering group for the Implementation of the Model of Care was established in April, 2018. The Group is co-chaired by the Programme's director of midwifery, Ms Angela Dunne and Programme's clinical director, Dr Peter McKenna. Membership is multidisciplinary with national representation. During 2018, the Steering Group has met on three occasions.

These meetings identified and scoped out specific work programmes required to drive and enable the implementation of the National Maternity Strategy. This also supports shared learning regarding work undertaken to date at both national and local level. Work programmes identified under the auspices of the Steering Group include workforce and education, communications, key performance indicators and structured engagement with service users. The Service Users Group subsequently convened ensure that users of the service are in a position to provide their insight and perspective to the on-going work stemming from the NWIHP, ensuring women and their families remain central to the implementation process. Additionally, a Midwifery Champions Group has been formed to gain the perspective of staff midwives who are essential to the implementation of the model of care.

As part of the work to develop and deliver the model of care as set out in the National Maternity Strategy, particular focus was assigned to the supported care pathway during the course of 2018. This pathway was identified as the one that was least developed across maternity services, notwithstanding some excellent examples of same in a small number of sites. The supported pathway is intended for pregnancies deemed to be normal-risk and care will be delivered by midwives working within a multidisciplinary framework. It is envisaged that within this pathway, the majority of antenatal and postnatal care will be provided in the community with continuity of care being a key principle.

Significant investment in additional midwifery posts, specifically to develop and deploy this care pathway in 2018, have enabled maternity services to make significant inroads in this area by means of developing midwifery led clinics on site or in community settings, commencing early transfer home schemes, consolidating and expanding existing supported care packages like DOMINO and developing home-away-from-home suites within the maternity networks.

The Programme working with the Department of Health, in investing in the supported care pathway, has developed a target that at least 20% of women would be offered the supported

care pathway within our maternity services. A key priority for the Programme in 2019 is the undertaking of a baseline exercise across all 19 maternity units to assess progress made in this regard and to report on same during the course of 2019.

#### 4.2 The NCEC Childbirth Guideline

This National Clinical Effectiveness Committee Guideline was commissioned by the Department of Health and focuses on risk classification for women presenting for antenatal care. The Guideline Development Group is chaired by Professor Michael Turner. A modified three-round Delphi process alongside a systematic and economic literature review was completed in conjunction with the Health Research Board Collaboration in Ireland for Clinical Effectiveness Reviews. This work commenced in June of 2017 and it is planned to finalise the guideline for endorsement of the NCEC in August 2019.

#### 4.3 Maternal and Newborn Clinical Management System

Phase 1 of the Maternal and Newborn Clinical Management System (MN-CMS) commenced with the “go-live” of Cork University Maternity Hospital (CUMH) in December 2106. In 2017 University Hospital Kerry and the Rotunda Hospital went live. The completion of Phase 1 was marked when the System went live at the National Maternity Hospital in January 2018.

A Phase 2 preparedness review commenced in late 2018, and will inform the decision about Phase 2 sites.

## Part 5: Governance and Accountability

### 5.1 Maternity Patient Safety Statements

Maternity Patient Safety Statements (MPSS) are published for each of the country's 19 maternity hospitals/units. Each maternity unit has published maternity patient statements since December 2015, publishing an updated statement each month, reporting two months in arrears.

The MPSS contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents.

The national reporting average of the MPSS for 2018 was 100%. The MPSS is reviewed on a regular basis by the Programme with the Maternity Networks.

### 5.2 Maternity Networks

A key recommendation of the National Maternity Strategy is the development of managed clinical networks – maternity networks – to ensure that all women receive consistent, high quality, safe care, across all 19 maternity hospitals/units. Maternity networks are the primary vehicle for ensuring governance and leadership of maternity services.

The Programme recognises that each hospital group has adopted a different approach to the establishment of clinical directorates, and has worked with all the hospital groups to establish maternity networks. Funding was provided in 2017 and again in 2018 to provide clinical and midwifery leadership to each network, with this level of support enhanced in 2018 with the funding and approval of quality and risk, data management and senior management personnel for the maternity networks.

The Programme met with the maternity networks on a regular basis throughout 2018 with an agreed agenda, looking at the implementation of the National Maternity Strategy and also on-going quality and safety issues. This year saw further work on clarifying the accountability structures to strengthen each network.

### 5.3 Serious Incident Management Forums

The development and implementation of maternity focused Serious Incident Management Forum (SIMF) within each Maternity Network is a key objective of the Programme. These SIMFs will provide robust and high level oversight of adverse outcomes within each Network and will underpin the quality & safety standards in the 19 maternity units.

The development of maternity focused SIMFs will ensure a robust process for accountability and the timely communication of learning in relation to the management of adverse events, with each network being supported to implement a standardised, timely and transparent response to adverse events as well as supporting and mandating the systems responding and learning in order to mitigate the chances of reoccurrence.

The SIMF model is based the natural justice principle of *Nemo Judex in causa sua* – no man shall be a judge in his own case. SIMFs support a hospital groups quality and safety framework and the HSE vision of shared learning pathways to improve quality and make our maternity units safer.

During the course of 2018, significant work was undertaken within the maternity network as to the development of their SIMFs in terms of their structure, membership, terms of reference and governance structures. During the course of 2019, the Programme is anticipating that SIMFs will be actively implemented across the individual maternity networks.

#### 5.4 Support Professionals and Promote Inclusiveness

The National Women and Infants Health Programme's Annual Clinical Forum met at Farmleigh House, Dublin in October 2018. This was a multidisciplinary meeting with speakers from across the country. Topics included various aspects of the maternity model of care; benign gynaecology; cervical cytology; transvaginal mesh; termination of pregnancy; neonatal encephalopathy and its impact and strategies to prevent and investigate it. The Forum was very well attended, with positive feedback in relation to same being received by the Programme.

#### 5.5 Funding

The provision of developmental funding €4.55m to the Programme in 2018 enabled the Programme to approve an additional 155 posts across the six maternity networks so as to enhance and develop the provision of care to women and infants. The cohort of posts approved included consultant obstetrician and gynaecologists, consultant pathologists, staff midwives, clinical specialist midwives, advanced midwife practitioners, health and social care professionals including medical social workers, dieticians and ultrasonographers, quality and safety officers and general managers at maternity network level. By the end of 2018, over half of the allocated posts were in place across the system, with active recruitment on-going regarding the remainder.

The approval and allocation of additional posts in 2018 was guided by the following priorities:

- Supporting increased access to anomaly scanning;
- Financial support to facilitate establishment of the managed clinical maternity networks in each hospital group;
- Financial support to increase equitable care across each maternity network irrespective of unit size; and
- Establishment of quality and patient safety resource in each managed clinical maternity network.

## 5.6 Parliamentary Affairs

The Programme also attended the Joint Committee on Health in February 2018. During the year, the NWIHP was assigned and responded to over 100 Parliamentary Questions and Representative Queries.

## Part 6: Additional Areas of Activity

### 6.1 The Use of Uro-gynaecological Mesh in Surgical Procedures

In July of 2018, the Department of Health's Chief Medical Officer paused the use of all procedures involving uro-gynaecological/transvaginal mesh implants for the management of Stress Urinary Incontinence or Pelvic Organ Prolapse in HSE funded hospitals.

The National Women and Infants Health Programme has taken the lead on behalf of the HSE in addressing this area. Specifically, the Programme is leading the response of the HSE to the Report entitled "*The Use of Uro-gynaecological Mesh in Surgical Procedures, Report to the Minister of Health Mr Simon Harris, from the Chief Medical Officer, 21<sup>st</sup> November 2018*", which contains 19 recommendations for which the HSE is responsible.

The HSE has established an Executive Group which has worked closely with the Health Procedures Regulatory Authority and service users to address matters raised by the Chief Medical Officer in this regard.

### 6.2 Termination of Pregnancy

Following from the referendum in May 2018, the Programme played a central role in the planning and implementation of termination of pregnancy (TOP) services in the public health care system as provided under the Health (Regulation of Termination of Pregnancy) Act 2018. The service has been designed and employed with a view to ensuring to the greatest extent possible that this service is provided and accessed by women in community settings.

In relation to the acute sector, all maternity hospitals are supporting the provision of termination of pregnancy services by means of providing the following services: managing complications arising from termination; providing appropriate care and supervision for women following a diagnosis of fatal foetal abnormality; and referral to the appropriate tertiary unit; and providing appropriate care and supervision in cases where maternal health/life is at risk, and referral to the appropriate tertiary hospital, as appropriate.

### 6.3 Model of Care for Assisted Human Reproduction

The General Scheme of the Assisted Human Reproduction Bill 2017 was approved by the Government in October 2017. An important aim of the legislation is to promote and ensure the health and safety of parents, and children born as a result of assisted human reproduction (AHR) treatment, as well as other parties who may be involved such as donors and surrogates. Further to the publication of the Bill, the HSE was requested by the

Department of Health to undertake a more in-depth examination and assessment of the potential scope of a model of care for AHR within the public health service. This was carried out by the Programme in the latter half of 2018. In preparing this scoping assessment, the Programme considered the following areas:

- the potential clinical pathways that could be involved in the model of care;
- how the model of care might be integrated within existing obstetric and gynaecological services;
- the potential role of the maternity clinical networks and the associated tertiary care centres;
- interaction with other on-going/intended developments within the context of the National Maternity Strategy, including resource and capacity considerations within the maternity networks; and
- an indicative timeline for the operationalization of the model of care, on an iterative basis, within the first three to five years.

The resultant Model of Care was submitted to the Department in October 2018 and it is envisaged that work will continue in this area in collaboration with the Department during the course of 2019.

#### 6.4 CervicalCheck Programme

Arising from the challenges being experienced within the CervicalCheck Programme during the course of 2018, the clinical director of the National Women and Infants Health Programme was appointed interim clinical director of the CervicalCheck Programme. Associated with this role was a significant work commitment which included overseeing the drafting and publication of the 'Data validation project for the 221 women impacted by cervical screening crisis', the commencement of a colposcopy impact assessment review due to be published in 2019 and the provision of on-going senior clinical leadership to the CervicalCheck Programme.

## Part 7: Priorities for 2019

In reviewing its 2018 work plan, and looking towards 2019, the Programme has identified the following priorities for 2019:

- Continue to support and drive the development of robust maternity networks within each of the hospital groups;
- Plan for and support the establishment of a Serious Incident Management Forum for maternity services in each hospital group;
- Ensure anomaly scanning is available to all women attending ante-natal services;
- Pilot the anaesthetics model of care for general hospitals with maternity services;
- Complete a national plan for benign gynaecology and plan for its phased implementation;
- Identify the suite of clinical guidelines required in maternity services and manage any gaps identified in terms of the development / review of new or existing clinical guidelines;
- Support and enable the implementation of a safe, high quality termination of pregnancy service;
- Define the detailed care pathways to be made available to women in all maternity services based on the model of care proposed in the national strategy thereby enabling a standardised and consistent planning approach;
- Prepare a detailed implementation plan for the recommendations set out in the report on the use of transvaginal mesh;
- Assess midwifery workforce levels against the 2016 Birth Rate Plus methodology within the context of the new model of care;
- Develop a national suite of KPIs for maternity services;
- Identify and define the educational supports and training programmes required by staff to ensure a safe, competent and supported maternity workforce; and
- Continue to work with maternity networks so as to develop the multidisciplinary teams needed in each network so as to provide women with the appropriate support before, during and after their pregnancy.



## Bibliography

- [Healthy Ireland Framework](#) (2013)
- [HIQA Portlaoise Report](#) (2015)
- [National Maternity Strategy 2016-2026](#) (2016)
- [National Maternity Strategy Implementation Plan](#) (2017)
- [National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death](#) (2016)
- [Specialist Perinatal Mental Health Services. Model of Care for Ireland](#) (2017)
- [Chief Medical Officer's letter regarding use of transvaginal mesh](#) (2018)
- [Irish Maternity Indicator System](#) (2018)

## Appendices

Appendix 1: Maternity Hospitals/Units in Ireland

Appendix 2: Stakeholders NWIHP have engaged with during 2018

## Appendix 1

### Maternity Hospitals/Units in Ireland

The four standalone maternity hospitals in Ireland are:

1. The Rotunda Hospital (RCSI)
2. National Maternity Hospital (IEHG)
3. Coombe Women and Infant's University Hospital (DMHG)
4. University Maternity Hospital Limerick (ULHG)

The 15 collocated maternity units are:

5. Cork University Maternity Hospital; collocated with Cork University Hospital (SSWHG)
6. Cavan General Hospital (RCSI)
7. Our Lady of Lourdes Hospital, Drogheda (RCSI)
8. Wexford General Hospital (IEHG)
9. St Luke's General Hospital (IEHG)
10. Midlands Regional Hospital Mullingar (IEHG)
11. Midlands Regional Hospital Portlaoise (DMHG)
12. University Hospital Waterford (SSWHG)
13. University Hospital Kerry (SSWHG)
14. South Tipperary General Hospital (SSWHG)
15. University Hospital Galway (Saolta)
16. Portiuncula University Hospital (Saolta)
17. Mayo University Hospital (Saolta)
18. Sligo University Hospital (Saolta)
19. Letterkenny University Hospital (Saolta)

## Appendix 2

Stakeholders NWIHP have engaged with during 2018

- Hospital Group CEOs
- HSE Acute Operations
- HSE Acute Strategy and Planning
- HSE Primary Care
- HSE Quality Assurance and Verification
- HSE Quality Improvement
- HSE Health and Wellbeing
- HSE Mental Health
- HSE Communications
- National Treatment Purchase Fund
- NHS Scotland
- National Perinatal Epidemiology Centre
- Office of Nursing and Midwifery Services Division
- Institute of Obstetrics and Gynaecology
- Irish Nurses and Midwives Organisation
- Directors of Midwifery Forum
- Advocacy groups
- State Claims Agency
- National Clinical Programmes;
  - Anaesthetics
  - Critical Care Programme
  - Paediatrics and Neonatology
  - Diabetes



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**Dublin, June 2019**