

Clár Sláinte Náisiúnta do Mhná & do Naíonáin

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National Women and Infants Health Programme

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16th December 2022

Deputy Cairns, Dáil Éireann, Leinster House Dublin 2

PQ58456/22: To ask the Minister for Health if he will set a national ambition to reduce the number of stillbirths and neonatal deaths.

PQ58457/22: To ask the Minister for Health if he will establish a committee/unit to study stillbirth and neonatal death as a public health issue and to make recommendations for reducing the number of stillbirths and neonatal deaths, including testing and screening for group B strep, vasa praevia, pre-eclampsia, and intrahepatic cholestasis of pregnancy.

Dear Deputy Cairns,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Questions, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

The two PQs submitted were already submitted and responded to by the HSE in July this year. For ease of reference I have attached a copy of the original response issued.

One of the key functions of The National Women and Infants Health Programme (NWIHP) is to provide oversight for the quality and safety of our maternity services. The ambition of NWIHP in this regard is to reduce the incidence of adverse events, including stillbirths and neonatal deaths, enhancing the safety of maternity care. Data collection and analysis is vital in the quality improvement process. Recognising this, NWIHP have encouraged the development and implementation of the maternity focused Serious Incident Management Forum (SIMF) within each Maternity Network as a key objective of the Programme. These SIMFs provide robust and high level oversight of adverse outcomes within each Network and underpin the quality & safety standards in the 19 maternity units.

In addition, the NWIHP have established the Obstetric Event Support Team (OEST) to assist in extracting learnings from adverse events, providing a mechanism for sharing this learning locally and nationally. The OEST have identified early neonatal death as one event that requires particular attention. Valuable data that can influence clinical practice in a constructive way is also reported via Patient Safety Statements (PSS) and the Irish Maternity Indicator system (IMIS). Annual IMIS reports can be found on the HSE website:

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-reports-on-womens-health/

The NWIHP work collaboratively with the National Perinatal Epidemiology Centre (NPEC) to support the functions of the department and help to close the audit loop. The NWIHP has demonstrated continued commitment to the collection of NPEC's audit data, report publication and the implementation of its recommendations. NWIHP welcomes the recommendations of the recent NPEC report on Perinatal Mortality in Ireland and looks forward to working closely both with NPEC and the Institute of Obstetricians and Gynaecologists to review stillbirth and neonatal deaths to identify causal factors, mitigating risk where possible.

An important work-stream of the National Women and Infants Health Programme (NWIHP) for 2021 and beyond, is the revision and update of the National Clinical Guidelines for Maternity and Gynaecology services. The HSE National Clinical Practice Guidelines for Group B Streptococcus Disease in pregnancy and Hyperemesis Gravidarum/Nausea and Vomiting in pregnancy are two of a suite of National Clinical Practice Guidelines which NWIHP commissioned in 2021. Guideline review will include consideration of both national and international best practices in the relevant clinical care areas, including those developed by NICE.

The review of these national clinical practice guidelines will be completed jointly by the HSE and the Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland.

I trust this clarifies the matter.

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Yours sincerely,

Mary-Jo Biggs, General Manager, National Women and Infants Health Programme

