



ANNUAL REPORT 2019

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Message from the Director

I am pleased to present the Health Service Executive (HSE) National Women and Infants Health Programme's (NWIHP) 2019 Annual Report providing a review of progress that has been made in implementing the "National Maternity Strategy – Creating a Better Future Together" during the year.

The focus on 2019 was on consolidating the progress made with the significant development funding in 2018. The NWIHP continued to focus on implementing the model of care, by growing the midwifery workforce to improve access to the supported care pathway. We also continued the investment in consultant obstetrician/gynaecologists, as part of the plan to increase the consultant workforce by 100 over the lifetime of the Maternity Strategy.

This report sets out some of the key developments under the four principles of the National Maternity Strategy: (NMS)

- 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; and
- Ensuring the appropriate resourcing, governance and leadership for maternity services.

In particular the development of the maternity networks, as the building blocks for implementing the NMS were firmly established during 2019, and the NWIHP's regular engagement with these networks has greatly enhanced our ability to target development funding.

The NWIHP is very grateful to our colleagues in the Department of Health's maternity and gynaecology unit for their continued support, and for securing additional development funding in 2019. The continued focus on maternity services at national level is helping to drive the implementation of the NMS, while providing a platform for further developments in 2020 in accordance with the NMS.

Kilian McGrane
Director
HSE National Women and Infants Health Programme

1. Background

Overview

In January 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. The National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death were also launched in August of that year, followed by the Health Information and Quality Authority’s publication of Safer Better Health Standards for Maternity Services.

In order to ensure a co-ordinated and focused approach to the work required 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 (DoH), created the National Women and Infant’s Health Programme.

In driving these policies, the NWIHP is responsible for the enhancement of maternity services, 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 2019, the NWIHP continued to build on its work commenced in 2018 with its work programmes being underpinned and informed by the four strategic priorities set out in the NMS. 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; and
- Ensuring the appropriate resourcing, governance and leadership for maternity services.

Our Objective

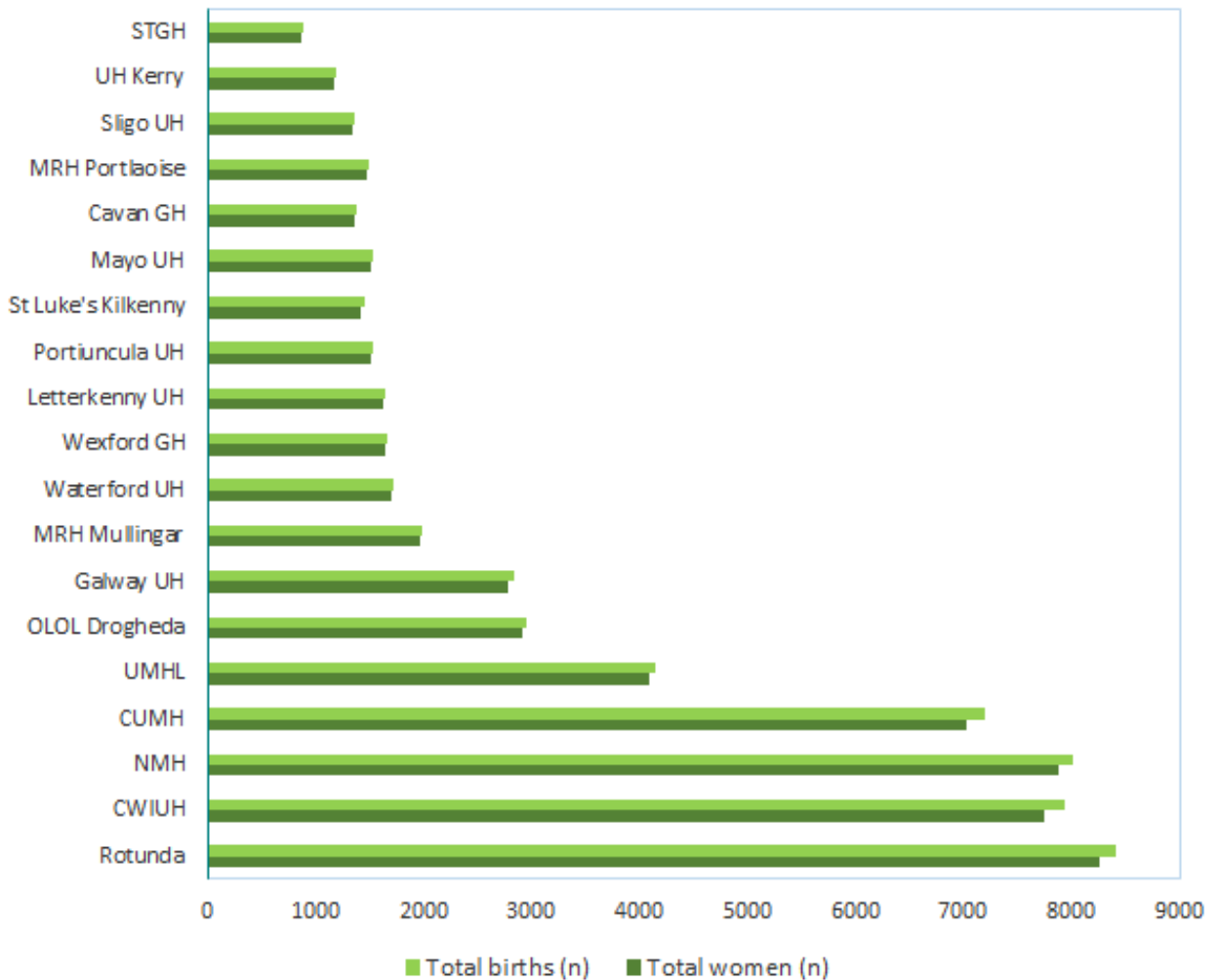
A core objective of the NWIHP Programme since its inception in 2017 is to standardise practices in maternity services. Standardised and equitable care nationally across all care settings is a fundamental focus of the NWIHP, to ensure that regardless of where geographically a woman presents for care to the public health services, each woman will have equal access to a consistent level of safe, quality health care services.

The work of NWIHP is done acknowledging that the vast majority of maternity services are currently delivered within an acute setting. However, increased levels of care are being moved from the acute setting and care is being delivered to women in the community as recommend by the Model of Care (MOC) for maternity services in the NMS.

With regular engagement meetings, we continue to build a strong working relationship with colleagues in the Department of Health and multiple stakeholders across the healthcare system at local, regional and national level. This continued engagement has been critical in order for the NWIHP to best understand the changing landscape and determining the most appropriate way to implement the NMS

The Maternity Hospital Units

All 19 maternity hospitals/units are part of the six hospital groups and their associated maternity networks. There are four standalone maternity hospitals and 15 maternity units located within or co-located with 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. See below the chart for Total births and Total women delivered in 2019.



Source: IMIS 2019 Report

Significant 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 it is planned that the four standalone hospitals will be co-located

with an adult teaching hospital, with work already actively underway in relation to the National Maternity Hospital, Holles Street in this regard.

The Team

The core team of the national Programme has within it a cohort of expertise including; medical obstetrics and gynaecology, midwifery and senior executive expertise, supported by quality and risk, project management, data management and administrative personnel.

This core team was further supported by a range of personnel and teams from multiple sections of the health service including but not limited to; the 19 maternity services and their staff, maternity networks' clinical and executive management teams, the HSE's 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 NWIHP acknowledges with thanks the work and contribution made by each of our collaborators and partners, in driving the development of better, safer services for women in Ireland. We were fortunate that Dr Gerry Burke worked for the NWIHP on a part time basis. His interest in the safety of babies and mothers is well known and the NWIHP appreciate the efforts he made on our behalf to keep these topics central. He left to take on a more substantial role with the Limerick Hospital Group and we are grateful for his contributions to us and the service.

The National Clinical Effectiveness Committee

The National Clinical Effectiveness Committee's (NCEC) mission is to provide a framework for national endorsement of clinical guidelines and clinical audit to optimise patient and service user care. The NCEC has a remit to establish and implement processes for the prioritisation and quality assurance of clinical guidelines and clinical audit so as to recommend them to the Minister for Health to become part of a suite of National Clinical Guidelines and National Clinical Audit. The aim of the suite of National Clinical Guidelines is to provide guidance and standards for improving the quality, safety and cost-effectiveness of healthcare in Ireland. The implementation of these National Clinical Guidelines will support the provision of evidence-based and consistent care across Irish healthcare services.

During 2019 the National Clinical Guidelines on risk in pregnancy underwent quality assurance by the NCEC. In partnership with the Collaboration in Ireland for Clinical Effectiveness Reviews (HRB-CICER), there was a systematic review of economic literature to support the stratification of clinical risk in pregnancy guideline and budget impact analysis of the implementation of the stratification of clinical risk in pregnancy guideline carried. This quality assurance is important because all women must be formally risk assessed throughout their pregnancy and at every contact so that they have continued access to care provision by the most appropriate trained professional. Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical pathway. It is expected that the guidelines will be published in 2020.

Key Areas of Work in 2019

As set out previously, at the point of its establishment the primary focus of the NWIHP was the enhancement of maternity services, gynaecology services and neonatal care.

However, with the implementation and development of a team at national level within the HSE which had a concentration of expertise and resources in an area primarily concerned with women's health related services, this has resulted in additional projects and work streams in the area of women's health being allocated to the Programme since its inception.

These additional work streams have all been readily embraced by the NWIHP, in the acknowledgement of the interdependencies and potential synergies that can be harnessed across the different services to continue to improve and develop women's health service within the public health service. Such additional projects and works streams have included model of care for infertility services, termination of pregnancy services, the use of uro-gynaecology mesh in surgical procedures, sexual assault and treatment services, colposcopy services and the Royal College of Obstetricians and Gynaecologists (RCOG) Review of Cervical Screening.

2. Development of Supported Care Pathway in Irish Maternity Services

Overview

The HSE's NWIHP, in its role of driving and advancing the implementation of the NMS, targeted significant investment in additional midwifery resources across the 19 maternity services in 2018. The objective of this investment was to enable services to further develop and/or deploy the supported care pathway and to enhance senior midwifery expertise in the services by means of additional Clinical Midwifery Manager 2 (CMM2), Clinical Midwifery Specialists (CMS) and Advanced Midwife Practitioners (AMP) posts.

Late in 2018, it was determined by the NWIHP that a baseline exercise would be undertaken of all 19 maternity services, with a view to reviewing the impact that these additional midwifery resources have had in terms of supporting the development of the supported care pathway, and working with services to identify on-going challenges, opportunities and priorities at local level.

This baseline exercise was undertaken through a series of site visits by the NWIHP to each of the maternity services and units during the first half of 2019. The development of the supported care pathway within maternity services was reviewed in the context of its three constituent parts – namely antenatal care, intrapartum care and postnatal care. The NWIHP would like to take this opportunity to acknowledge with much thanks and appreciation the time and input of the Directors of Midwifery and their teams across the 19 services into this exercise.

Output

The output of this exercise was a report which established an initial national baseline of information on maternity services in Ireland further to the NMS. A number of key findings were identified as part of this exercise, both in relation to the supported care pathway and in relation to areas such as infrastructure, scanning services, specialised and senior midwifery care and specialised care pathways available. These findings included:

- 16 of the 19 maternity services were providing the antenatal component of the supported care pathway;
- 10% – 35% of women presenting to maternity services were managed in the supported care pathway antenatally;
- All women in the supported care pathway engaged in a shared model of care with their GP under the Mother and Infant Care Scheme;
- 15 maternity services held midwifery provided clinics in the community;
- 10 maternity services provided booking in clinics in the community;
- 3 maternity services provided homebirth services directly;

- 11 maternity services had in place early transfer home (ETH) services with the percentage of women accessing this service ranging from 5% to 30%;
- ETH care packages consisted of anywhere between 1 to 5 home visits by a midwife depending on the needs of the woman following birth;
- A total of 114 delivery suites were available within maternity services in Ireland;
- 11 home-away-from-home delivery suites were available in Ireland including those in the two midwifery led units in Drogheda and Cavan;
- Ten labouring pools were available in maternity services, one of which was used for birthing;
- All 19 services reported 100% provision of dating scans to women;
- 15 services were providing anomaly scanning to all women presenting, whilst the remaining 4 services were providing such scans based on clinical indications whilst actively working towards full provision;
- Twelve maternity services did not have in place any advanced midwifery practitioner posts, with further development of the AMP role in maternity services being identified as critical;
- All 19 services had in place CMS posts, however the numbers of such posts varied widely across services, with significant inconsistencies across services as to what would be deemed core CMS roles e.g. lactation;
- The scope and range of specialised care pathways within individual maternity services, was entirely appropriately, dependent on the availability of expertise within the service and the wider clinical community. Examples of such pathways included bereavement, lactation, multiple pregnancies, teenage pregnancies, infectious disease and fetal medicine;
- All 19 services reported having in place structured referral pathways with tertiary centres for the care and management of the woman and/or baby as clinically required;
- Access to allied health professional services including medical social work and dietetics and ancillary support services e.g. drug liaison and addiction services, were identified as extremely variable across the 19 services.

When compared to the structure and delivery of maternity services at the point of development and publication of the NMS, there is no doubt that significant advances have been made within maternity services in deploying the MOC as defined in the NMS, with services using the additional resources allocated to develop the model of midwifery provided care and target the provision of that care in the community. To communicate and celebrate the achievements of services to date in advancing the NMS, whilst recognising the significant work still to be undertaken to fully realise the vision of the NMS, the NWIHP developed and circulated an information poster for staff to all 19 services.

Objectives for 2020

The undertaking of the baseline exercise provided the NWIHP with a wealth of information and data. Informed by this exercise, the NWIHP identified a suite of actions as part of its 2019/2020 programme of work, including:

- Development of submission for 2020 Estimate Process informed and underpinned by the key findings of this baseline exercise;
- Support the provision of home-away-from-home facilities in a number of sites where such is achievable by means of local refurbishment projects;

- Identify and support local initiatives that could be applicable to other services that promote midwifery care e.g. Hopscotch;
- Promote and support the development and roll out of the National Patient Experience Survey within maternity services;
- Roll out of the National Healthcare Communication Programme to maternity service providers; and
- Support and engage with services as to the structure and delivery of early transfer home services so that going forward this care is available based on women's need as distinct to length of time of postnatal care on acute site.

3. National Maternity Experience 2019

Overview

The Maternity Experience Survey was overseen by a National Steering Group and a Programme Board. The survey is part of the National Care Experience Programme, a joint initiative by the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE), National Women and Infant's Health Programme and the Department of Health. The National Maternity Experience Survey offers women the opportunity to share their experiences of Ireland's maternity services.

Output

The National Care Experience Programme seeks to improve the quality of health and social care services in Ireland by asking people about their experiences of care and acting on their feedback. The survey reflects a commitment made in The National Maternity Strategy 2016-2026 to evaluate maternity care services from the perspectives of the women who use them. In addition, a number of survey questions reflected the key themes from The National Maternity Strategy 2016-2026, such as choice, promoting health and wellbeing, involvement in decision-making and being treated with respect and dignity.

6,357 women who gave birth in October and November 2019 were invited to participate in the first National Maternity Experience Survey. The survey questionnaire contains 68 questions which capture the whole maternity pathway from antenatal care, through labour and birth, to postnatal care in the community.

The aim of the survey is to learn from the experiences of women to improve the safety and quality of the care that they and their babies receive. HIQA, the HSE and the National Women and Infants Health Programme and the Department of Health have committed to acting on the findings of the National Maternity Experience Survey to improve the quality of maternity care services in Ireland.

Objectives for 2020

Quality improvement plans will be developed in 2020 by the HSE, the NWIHP at national and local levels to address the issues highlighted in the survey.

4. HSE - National Breastfeeding Implementation Group

Overview

The National Breastfeeding Implementation Group is working to achieve the aims and objectives of the Breastfeeding Action Plan through the implementation of initiatives in the following areas:

1. Improved governance and health service structures;
2. Breastfeeding training and skills development;
3. Health service policies and practices;
4. Support at all stages of the breastfeeding continuum through social marketing, support and advocacy; and
5. Research, monitoring and evaluation.

The following is a brief update on the main actions of the Breastfeeding Action Plan relating to maternity services that were undertaken in 2019.

Outputs

1.1 Improved Governance and Health Service Structures

The NWIHP are overseeing the development of a revised model for the Baby Friendly Initiative (BFI) in Ireland. In July 2019, the national BFI standards project group concluded a National Infant Feeding Audit with 17 maternity hospitals/units. The findings from this audit report will inform the implementation phase of the programme of work.

Through the national estimates process, funding for 3 additional infant feeding specialist posts were secured in 2019. It is expected that these posts will be filled in early 2020.



'Latching on' morning at Áras an Uachtaráin. Hosted by Ms Sabina Higgins 4th October 2020

A report outlining recommendations for the governance and operation of community and hospital breastfeeding/infant feeding committees was published in September 2019. This report was developed following a survey with 21 infant feeding committees in Ireland. It is envisaged that these recommendations will enable consistency in how committees operate and share best practices.

1.2 Breastfeeding training for healthcare professionals

Breastfeeding training and education seminars were facilitated by many maternity services throughout 2019. The Nurture Programme is funding a blended learning training programme that includes both online and face to face training. The eLearning modules “Supporting Breastfeeding” and “Managing Breastfeeding Challenges” have each been completed 521 times by staff working in acute hospitals. The development of a national breastfeeding skills based education programme was progressed in 2019.

1.3 Health Service Policies and Practices

The National Infant Feeding Policies for Maternity and Neonatal Services for Primary Care Teams and Community Services were updated and published in March 2019. These policies were developed with lactation consultant advisors input and following consultation with key staff groups.

The HSE Code of Marketing of Breast Milk Substitutes and Breastfeeding in the Workplace Policy for Staff Working in the Public Health Service were both progressed and are at a final stage of development at the end of 2019. Implementation of both policies is expected to begin by Q2 2020.

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

The National Breastfeeding Implementation Group is partnering with the Nurture program to develop supports for mothers at all stages of the breastfeeding continuum. The new mychild.ie website is now home to the HSE’s information on breastfeeding for families. The popular *Ask our Breastfeeding Expert* e-mail information and advice service runs 7 days a week, with live chat available from 10-3 Mon-Fri. This service delivered over 3,000 contacts in 2019.

The HSE’s publication *Breastfeeding – A good start in Life* was updated and published in April 2019. This booklet is available to all new families and can also be ordered from healthpromotion.ie.

This revised edition includes tips and advice on establishing breastfeeding, importance of exclusive breastfeeding, where to find support with breastfeeding, maximising breast milk and managing some common challenges.



National Breastfeeding Week was celebrated and promoted by MyChild.ie from 1st – 7th October 2019. The Chairperson of the National Breastfeeding Implementation Group, Carmel Brennan reported that ‘This year’s campaign is one of our most successful. We received huge support from consultants,

midwives and public health nurses to help promote our message of the importance of skin-to-skin contact for all babies”. The week was also supported by a social media plan across Twitter, Facebook and Instagram with a potential reach of 1.3m. There were over 100 events with extensive print, radio and TV coverage of features supporting breastfeeding in the weeks surrounding National Breastfeeding Week.



This photo was taken at the launch of National Breastfeeding Week and went on to win 3rd prize for Dara Mac Dónaill in the Press Photographers Association of Ireland awards.

1.5 Research, Monitoring and Evaluation.

The NWIHP through partnering with the work of the Irish Maternity Indicator System (IMIS) has enabled the collection of national breastfeeding data from maternity hospitals/units in a timely manner. The following breastfeeding metrics are now included

- Breastfeeding initiation rates
- Breastfeeding on discharge (exclusive and non-exclusive) rates

Data for these metrics will be available in the 2019 IMIS annual report. Having access to timely national data will be a huge benefit in monitoring progress and understanding breastfeeding trends in Ireland.

Touching scene: why skin-to-skin care is best for newborns . . . and parents

Direct skin-to-skin contact has been shown to have many benefits including bonding, stabilising of the baby's temperature and heart rate and lowering of stress

© Mon, Sep 23, 2019, 06:01

Sheila Wayman



Mother Sinéad Ward and baby Riona Roche in the Neonatal ICU at the Coombe Hospital. Photograph: Nick Bradshaw for The Irish Times

Objectives for 2020

Priority areas identified for implementation in 2020 include:

- Implementation of HSE Policy on the Marketing of Breast milk substitutes & Breastfeeding in the Workplace Policy for Staff Working in the Public Health Service;
- Progress the Baby Friendly Initiative, including implementation of findings from National Infant Feeding Audit and publish revised BFI standards;
- Continue to develop the blended learning training programme:
 - Promote the eLearning breastfeeding training for healthcare professionals
 - Develop the skills-based breastfeeding training for healthcare professionals;
- Continue to advocate for resources, through the estimates process to provide additional breastfeeding supports in maternity hospital/unit and in primary care. Funding is required to support key action areas including the appointment of Lactation Consultants in maternity hospitals/units and CHO areas, for the provision of breast pumps for mothers of preterm and sick infants and to facilitate effective implementation of policies; and
- Establish a Breastfeeding Stakeholder Forum.

Available data from community key performance indicators show some areas have made great progress in improving breastfeeding rates. However, national data shows the considerable progress that we need to make if we are to achieve the targets of the HSE Breastfeeding Action Plan (2016-2021). Breastfeeding at the first PHN visit is 55.8 % (2018, exclusive and non-exclusive) and 40.1% at 3 months (2018 - exclusive and non-exclusive).

5. Nurture Programme – Infant Health and Wellbeing

Overview

The vision of the Nurture Programme is to improve outcomes for all children and families from conception to the child's 3rd 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 objectives and key deliverables of the Nurture Programme as relevant to the antenatal period were closely defined at the programmes outset in 2016 and were later found to align closely with the recommendations of the National Maternity Strategy.

Outputs

Key outputs achieved in 2019 by the Nurture Programme include:

- Finalising antenatal education standards with all key stakeholders;
- Development of a capacity building training programme for antenatal educators. This was agreed as a priority in response to findings of consultation carried out on key dependencies for successful implementation of draft standards;

- Promotion and embedding of the MyPregnancy Book as a core service resource, including transition to the NWIHP as part of the sustainability plan for on-going delivery to all expectant parents. Agreement was also secured to have the MyPregnancy book translated in Arabic in 2020 ; and
- Developing further content for the mychild.ie website in response to user feedback

Underpinning all of this work was consultation with a wide range of key stakeholders to meet service user needs and ensure sustainability of all outputs.

Objectives for 2020

As work continues within the Nurture Programme in 2020, guided by its overarching deliverables and priorities, key objectives for the Programme in 2020 include:

- Launching the antenatal education standards;
- Commencing the delivery of an antenatal education curriculum for practitioners; and
- Continuing to develop and contribute to the on-line educational resource for parents and families mychild.ie website

6. Irish Maternity Indicator System (IMIS)

Overview

The Irish Maternity Indicator System (IMIS) is a system which captures and presents key data metrics from all 19 maternity services each year. It encompasses a range of multidisciplinary metrics including hospital management activities, deliveries, serious obstetric events, and neonatal metrics and laboratory metrics. The key stakeholders for this system include senior management at the 19 maternity hospitals/units, IMIS Quality Assurance Officers, Hospital Group senior management and the NWIHP. Data are collected for the IMIS within hospitals on a monthly basis. They are reviewed and signed off by the hospital senior managers. The data for the full year are sent retrospectively to the NWIHP, usually by March of the following year.

The IMIS provides data for a selected suite of metrics in a timely manner for internal hospital monthly reviews. It also provides data for national review on an annual basis. The IMIS is the only instrument of its kind in Ireland and, to our knowledge, internationally.

Outputs

The NWIHP produces IMIS annual national reports and individual hospital reports. The turn-around time for reports is dependent on timely data returns from all 19 maternity hospitals/units. Set out below is a summary of selected IMIS metrics for 2019:

- Total births have fallen by 21.5% over the past decade. In 2019, the rate was 2.8% lower than the previous year.
- The rate of nulliparas has fallen significantly by 8.4% since 2008 ($p \leq 0.001$). More nulliparas attend large maternity hospitals than smaller units, which is an important metric for hospital future planning of maternity healthcare provision.
- The fall in the national rate of perinatal deaths of 20.9% ($p \leq 0.001$) over the past decade is notable.
- The IMIS Manager collaborated with the HSE National Breastfeeding Co-ordinator to incorporate three new metrics for breastfeeding on the IMIS in 2019. Definitions were devised in accordance with the HSE Breastfeeding Action Plan 2016–2021 and data were collected for breastfeeding initiation and breastfeeding exclusively and non-exclusively on discharge. The breastfeeding initiation rate was 63.7% in 2019, which is among the lowest in the world. The IMIS data will inform the Breastfeeding Action Plan.
- In 2019, there was a welcome fall in rate of eclampsia. Over the past decade the rate of eclampsia has fallen by 78.5%.
- Two cases of miscarriage misdiagnosis per annum have been reported since the metric was introduced on the IMIS in 2017. This is disappointing, given improvements in Early Pregnancy Assessment Units after 2011 (Ledger and Turner, 2016) and the development of a national training program and the national clinical guideline, *Management of Early Pregnancy Miscarriage (2012)*.

- The IMIS data indicate very few General anaesthetics for CS (1.8% of total women delivered, and 5.2% of total CS).
- The rate of labour epidurals was 40.6% nationally.
- National increases in rates of induction of labour and CS continued in 2019, increasing by 0.5% ($p \leq 0.001$) and 1.7% respectively, on the previous year.
- The VBAC metric was introduced in 2019. While the national rate was low, there was considerable missing data on this metric and/or on the denominator (total women with one previous CS). Corrective steps are being taken at all units to ensure improvements in 2020.

Objectives for 2020

The IMIS will continue to be implemented on a monthly basis at the 19 maternity hospitals/units. It will continue to be used to inform hospital reviews and planning as well as reviews among the Hospital Groups and the NWIHP.

The Robson Ten Group Classification System (TGCS) was incorporated in the IMIS process on a pilot basis in January 2019. Robson TGCS is a classification system by which all perinatal events and outcomes can be compared. The system classifies all pregnant women into one of 10 groups, that are mutually exclusive and, as a set, comprehensive. Approximately half of hospitals provided complete data. In mid-2019, the IMIS Manager engaged with the National Perinatal Epidemiology Centre (NPEC), which previously gathered information on the Robson TGCS. It was agreed that from 2019 data collection would be centralised on the IMIS, with hospitals reporting on one instrument only. We plan to continue collaboration with the NPEC to improve data collection and ensure uniformity across all 19 maternity units.

7. Smoking Cessation Pilot

Overview

As per the Healthy Ireland Framework and the NMS providing support to women who smoke before, during, and after pregnancy is an important aspect regarding the Health and Wellbeing of women.

Output

During 2019, the smoking cessation Programme continued to work with the HSE Tobacco Free Ireland Programme to introducing a pilot smoking cessation initiative in the Rotunda Hospital, building on their existing commitment to providing this service. Funding was allocated by the NWIHP for a clinical midwife specialist in smoking cessation to the Rotunda Hospital with recruitment underway in late 2019. Work will continue into 2020 with the Rotunda, piloting carbon monoxide monitoring amongst women who smoke with follow up referrals being made available to the dedicated smoking cessation resource further to their booking visit.

Objectives for 2020

The Tobacco Free Ireland Programme and the NWIHP submit an application to SláinteCare for funding which would allow a structured smoking cessation pilot to be extended to two further maternity services. The team was successful in its entry and received funding for two clinical midwife specialist posts. In 2020, it is anticipated that this pilot will be rolled out to two further larger maternity hospitals – namely Cork University Maternity Hospital and the National Maternity Hospital, Holles Street.

8. National Standards for Bereavement Care

Overview

A specific focus to the Health and Wellbeing chapter of the NMS 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 Cork University Maternity Hospital (CUMH) was appointed as National Implementation Lead for the Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death. Ríona Cotter was appointed as programme manager for same in March 2017.

The implementation programme commenced in March 2017 and concluded its work in April 2019. In June 2019 the Programme Manager and the National Implementation Lead were funded to extend their work with the bereavement Standards by the NWIHP for a further 18 months. This extension period will facilitate the continued implementation and on-going development of the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death in the 19 Maternity Units in the Republic of Ireland.

Key Outputs

1.1 *National Implementation Group*

The Implementation process was 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 met three times in 2019 with the last meeting to conclude their work held in March 2019. A report was prepared on the work of the Standards implementation programme on behalf of the NIG and submitted to the NWIHP.

1.2 *National Oversight Group*

The National Oversight Group was established to oversee the continued implementation and on-going development of the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death in the 19 Maternity Units in the Republic of Ireland. It has a membership of 35 people, with representation from parent support groups, pregnancy loss support groups, and a number of multidisciplinary healthcare professionals involved in the provision of bereavement care.

1.3 *Quality Service & Improvement*

Following on from the audit that was carried out in all Maternity hospitals in 2017, the hospital audit tool was updated for use when all hospitals will be visited and audited again in 2020.

1.4 Policies & Procedures

Pathways for all types of pregnancy loss were finalised and published in 2019. These pathways were distributed to all Maternity Hospitals by the NWIHP and published on the pregnancyandinfantloss.ie website. The medication protocols for the medical management of first and second trimester miscarriage and intrauterine fetal death were also updated and distributed to all Maternity Hospitals by the NWIHP and published on the pregnancyandinfantloss.ie website.

1.5 Staff training & Support

The Standards for Perinatal Bereavement Education were finalised and published in 2019. Following on from a recommendation from the NIG, funding was secured from the NWIHP to train the Bereavement CMS Group as facilitators of the Irish Hospice Foundation providing training in Dealing with Loss in the Maternity Setting. This will support the CMS group to provide bereavement training to staff within their own Maternity Units. This training will be rolled out in 2020.

The TEARDROP (Teaching, Excellent, pArent, peRinatal, Deaths-related, inteRactions, tO, Professionals) workshop was designed to address the educational needs of **ALL** health professionals involved in maternity and new-born care in managing perinatal death and pregnancy loss and is based on the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death. The workshop functions as small groups of learners rotating around six interactive learning stations that are facilitated by experienced educators and clinicians. It was offered to all multidisciplinary team members involved in the provision of Perinatal Bereavement Care. This was run in August 2019 in CUMH and attended by 48 CUMH staff. This course was positively evaluated in August 2019. It has been organised to run again in January 2020, for members of the South Southwest Hospital Group (SSWHG). It is planned to offer this training to all Maternity hospitals in 2020.

As part of the National Oversight Group an Education Development subgroup has been setup. The purpose of this group is to oversee the on-going development of and implementation of appropriate bereavement education and staff support programmes for members of the multidisciplinary team involved in the provision of bereavement care in the 19 Maternity Units in the Republic of Ireland. This group first met in November 2019 and agreed to make recommendations for perinatal bereavement education programmes. The group has also undertaken to consider what staff support programmes are available for Maternity staff and make recommendations for same.

1.6 Referrals & Integration

Collaboration with the support groups continued in 2019. Following on from a request from the groups a programme of education for the groups has been developed and will be provided in early 2020.

1.7 Perinatal Palliative Care

This group worked in conjunction with the National Neonatal/Perinatal Palliative Care group (as part of the National Programme for Paediatrics & Neonatology). A pathway for the management of fatal fetal anomalies and/or life-limiting conditions diagnosed during pregnancy/perinatal palliative care was finalised and published in 2019.

1.8 Web Based Information

The NIG determined that a defined website would be developed for the sharing and dissemination of the documents produced by the NIG. This website was necessary to ensure that health care professionals delivering bereavement care have access to up to date, accurate information and advice.

A website development group was set up to develop a website for parents and healthcare professionals that will provide an interface between the groups and agencies which provide support for pregnancy loss. The development group was also responsible for the planning and oversight of the development of a website which is to be used as a “hub” for perinatal bereavement care to be used by both parents and health care professionals.

The website is to 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 is also a repository for patient care documentation that staff can use e.g. patient information leaflets, direct admission cards etc.

The website “Pregnancy and Infant Loss Ireland” is the *first-of-its-kind website for Ireland*. It is seen as a valuable resource for parents who experience pregnancy loss or perinatal death and strives to provide accurate and accessible information on a sensitive and often stigmatised subject, shares the latest research into the causes of baby loss, promotes emotional well-being, and offers details on how to access the appropriate support services. The website was launched on April 15th 2019.

Since its’ launch in April 2019 the website management Group have met on two occasions. The website has had one update carried out following on from feedback received from this group and users. The traffic on the website increased each month in 2019, with new users visiting the site each month.

1.9 Other activities

Parents’ forum

This was set up and had its first meeting in November 2017. They continued their involvement with the Standards implementation until the conclusion of the implementation programme in April. A number of the parents’ forum are parent representatives on the National Oversight Group.

Bereavement Specialist Midwife/Nurse Network

A support network for this group was set up and met for the first time in September 2017. The group met in Spring 2019 and the running and continuation of the group was handed over to the group by the programme manager.

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. While ten of the hospitals already had a CMS/CNS or a partial WTE in post the remaining 9 did not. A recruitment process was commenced in 2017 and by December 2017, 13 of the 19 maternity hospitals/units

Bereavement Clinical Midwife/Nurse Specialists were recruited and in place. As of the end of 2019 all posts have been recruited. The filling of two posts has been delayed due to the HSE recruitment freeze.

Conferences

Members of the NIG have spoken about bereavement care and the implementation of the Standards at various meetings and conferences throughout 2019. In March 2019 the Bereavement Standards Forum was held in University College Cork. This event was attended by 120 people which included staff representing all the 19 Maternity hospitals, parent representatives and members of the pregnancy loss support groups. Members of the NIG presented various aspects of the Standards implementation work at the International Stillbirth Alliance conference which was held in Madrid in October 2019.



Bereavement forum 2019: L-R. Dr Keelin O'Donoghue Consultant Obstetrician & Gynaecologist, Dr Peter McKenna National Clinical Director NWIHP, Rióna Cotter National Standards for Bereavement Care Programme Manager, Kilian McGrane National Programme Director NWIHP, Angela Dunne Director of Midwifery NWIHP

Support & Advisory role

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

Standards Update

The Standards were due to be reviewed in August 2019. A Standards review group was set up and met for the first time in November 2019. The review and updating of the Standards document is in progress.

9. Quality and Safety – Neonatal Encephalopathy

Overview

Ireland is one of the safest countries in the world to have a baby. However, a small portion of babies die or suffer severe brain injury because of events in pregnancy, many of which occur during labour. The impact of these incidents is profound with lifelong consequences for the babies and families involved.

Neonatal Encephalopathy (NE) is a clinical condition in the term infant defined by abnormal neurological behaviour, with the onset occurring shortly after birth. NE is manifested by an abnormal level of consciousness, with or without the presence of seizures and is often accompanied by difficulty initiating and maintaining respirations, depressed tone and depressed reflexes, poor suck and swallow. NE incidence is estimated as 3.0 per 1000 live births. There are subgroups of infants with NE who will have been exposed to a Hypoxic-ischaemic insult in-utero and therefore are assigned a diagnosis of Hypoxic Ischaemic Encephalopathy (HIE). HIE incidence is 1.5 per 1000 live births. Therapeutic Hypothermia (TH) has been found to be protective in those infants presenting with moderate or severe HIE by inhibiting various events in this cascade of HIE injury. TH is administered in the four tertiary hospitals only.

The National Neonatal Encephalopathy Action Group (NNEAG) is a formal partnership arrangement between key stakeholders to deal with issues of joint concern around incidence of Neonatal Encephalopathy (NE) in Irish maternity units and hospitals. The purpose of the NNEAG is to identify and address issues relating to avoidable incidents of NE. Primarily this is a risk management group tasked with identifying and addressing factors that are known to contribute to avoidable NE and improve the quality of care within our service. The purpose of the Group is to seek to reduce avoidable instances of NE through the identification of causes and risk factors and driving initiatives to eliminate or mitigate same. The expected outcome is an improvement of the quality of care with a reduction of avoidable NE cases in our 19 national maternity units/hospitals. It is hoped measurable improvements will be seen over the next few years. The membership of the group comprises of senior representatives from all stakeholder groups to include representation from HSE, Department of Health, State Claims Agency and patient advocates. The NNEAG reports to the HSE Chief Clinical Officer and will form part of the HSE's larger patient safety framework.

Outputs

In 2019, the NWIHP launched its second TH report in collaboration with the National Perinatal Epidemiology Centre (NPEC) and the National Clinical Programme for Paediatrics and Neonatology (NCPN). This Report serves two purposes. Firstly, it documents the maternal and infant clinical data for the cases requiring TH in 2018 and secondly it provides the composite data for all TH cases in the three year period 2016-2018. The strength of this report is that it is based on a geographically defined

region, namely the Republic of Ireland. All cases of TH have been captured. This makes the findings representative and eliminates selection bias.

Analysis of the data provides information on how the management of TH cases could be improved. It identifies risk factors for the development of NE. As the collection of TH cases gets larger, it may be possible to quantify these risks in a manner that can influence clinical practice. The process of reducing the incidence of NE requiring TH treatment will be an aggregation of marginal gains. While sentinel events may be difficult to predict, improved risk assessment (maternal disease) and better risk identification and stratification (IUGR, male foetus, primigravida woman, induction of labour) will identify at risk babies including sentinel event risks. Clear, agreed national care pathways and the standardisation of multidisciplinary training should achieve improvements and lead to increasing positive outcomes for infants including a reduction in NE. Furthermore, the findings will enable us to contribute to the international consensus and expertise in the development of evidence-based quality improvements initiatives.

Key Messages from the 2018 TH report were as follows;

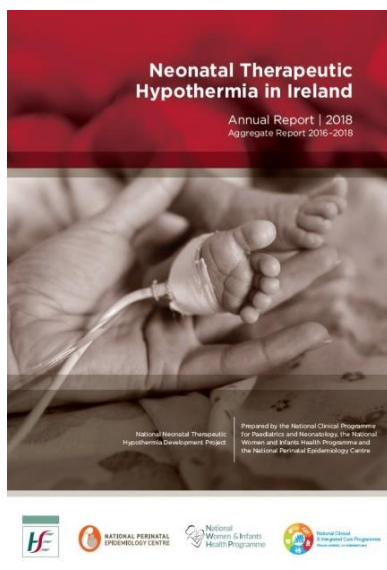
- In 2016/2017/2018, a total of 209 NE infants were treated with TH. The incidence of NE one in 899 infants born in Ireland. The incidence of NE has remained unchanged in the 3-year period. Without consistent data collection, analysis and action the incidence of NE will continue to be the same.
- NE is a significant cause of enduring morbidity and is the largest cause of mortality in normally formed term infants. The total survival rate for infants in the TH cohort for the time period 2016/2017/2018 was 88.6% with 24 infant deaths.
- The antenatal detection of intrauterine growth restriction is important. During the 3-year period 18% of infants who underwent TH were small for dates (<10th centile) for their gestation at birth with under 5% being identified antenatally.
- The standardisation in the interpretation of CTG and subsequent clinical response should be encouraged.
- The diagnosis and appropriate management of maternal pyrexia, shoulder dystocia and uterine rupture are recurrent challenges.
- There should be a heightened awareness of antecedent obstetric risk factors including primigravida mothers, endocrine disorders, assisted reproduction and previous caesarean section.
- Over the 3-year period, 82% of infants achieved optimum core temperature range within 6 hours of birth. The cooling candidacy checklist is an effective, reliable tool in the identification of infants requiring TH treatment with moderate and severe encephalopathy. Through the maintenance of an annual register evolving evidence of therapeutic creep will be captured.

- In total 40% of TH infants were born in a peripheral hospital and required transfer to one of the four tertiary centres that administer TH. The National Neonatal Transport Programme (NNTP) plays an important role in the retrieval of NE infants from peripheral hospitals.
- Placental examination was undertaken in 54% of NE cases. The commonest abnormalities were chorioamnionitis (30%) and Maternal Vascular Malperfusion (MVM) (27%). In many cases the placental findings provides an explanation of the cause of NE.

On the 24th January 2020 the NCPPN in collaboration with the NPE) and the NWIHP launched the TH 2018 Report at a study day in the Alex Hotel ‘Changing Patterns in Neonatal Encephalopathy in Ireland’. This was a well-attended event by Obstetricians, Obstetric trainees, Midwives, Paediatricians, Neonatologists, Paediatric trainees and Neonatal Nurse managers. The feedback was very positive from those who attended the event with attendees citing how ‘clinically relevant the material presented was’ and ‘how informative the day was overall’.

Objectives for 2020

It is the NWIHP intention to continue to share and update/educate staffs with regard to NE, TH and the evolving data from the annual reports to those working in the clinical areas through means of continued presentations and education sessions.



NWIHP Director Kilian McGrane presenting at the ‘Changing Patterns in Neonatal Encephalopathy in Ireland’ Study Day.

A national E-register will be utilised in 2020 for the first time to collect 2019 TH data. Continued anonymous collection of TH data 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.

The Alex

41-47 Fenian Street, Dublin 2

Changing Patterns in Neonatal Encephalopathy in Ireland

24th January 2020 11:00 - 15:00

Registration 11.00-11.30
Tea/Coffee Reception

11:30 National Therapeutic Hypothermia (TH) Report 2016/2017/2018
John. F. Murphy, Clinical Lead, National Clinical Programme for Neonatology/
Consultant Neonatologist, National Maternity Hospital

12:00 Emergencies in Term Labour
Richard Greene, Consultant Obstetrician, Cork University Maternity Hospital/
Director, National Perinatal Epidemiological Centre

12:30 Questions & Discussion
12:45 Lunch

13:15 Early Messages
Peter McKenna, Clinical Director, National Women and Infants Health Programme

13:45 Treatment in the first 6hrs of life for babies requiring TH
Peter Filan, Consultant Neonatologist, Cork University Maternity Hospital

14.15 Brain MRI in Neonatal Encephalopathy
Stephanie Ryan, Paediatric Radiologist, Children's University Hospital, Temple Street

14:45 Questions & Discussion

Places are limited. Please contact Julie McGinley on jmcginley@nmh.ie to register your place by 4th November 2019.



NWIHP Clinical Director Dr Peter McKenna presenting at the 'Changing Patterns in Neonatal Encephalopathy in Ireland' Study Day.

Finally, the work of the NNEAG will continue into 2020/21 with the identification of work streams which will continue the engagement with all stakeholders going forward and the appointment of a full time Project Lead.

10. Anomaly Scanning

Overview

The HSE recognizes that fetal anomaly scanning is a necessary component of good quality antenatal care. The implementation of the NMS will assure equitable access to standardized 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 services were offering 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 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.

Outputs

Funding for 28 additional ultrasonographers was subsequently secured through the annual estimates process, with these posts allocated to individual maternity services based on the needs assessment undertaken. Investment was also made by the NWIHP in upgrading/replacing and investing in additional Ultrasound (US) machines in a number of sites. On foot of this investment, towards the end of 2019 eighteen units and services were on target to provide all women booked with them with an anomaly scan at the 20 – 22 week mark of gestation, whilst the nineteenth service continued to provide the scan but at a later stage of pregnancy.

11. Specialist Perinatal Mental Health Service

Overview

As many as 1 in 5 women have mental health problems in pregnancy or the year after birth. Depression and anxiety are the most common mental health problems in pregnancy and affect about 10 to 15 out of every 100 pregnant women. Two years on from the launch of the Specialist Perinatal Mental Health Model of Care for Ireland, the Model supports the seven actions on mental health outlined in the Government's NMS. Whilst the focus of this specialist service is on women with moderate to severe mental illness, it also ensures women with milder mental health problems are both identified and receive appropriate help from skilled staff within maternity services. This is done through the development of the role of the mental health midwife nationally and plays a central role in educating and training all involved in the delivery of services to women during the antenatal and postnatal periods. The specific circumstances of pregnancy, birth and early mother/infant bonding requires staff that are knowledgeable, skilled, sensitive and experienced in responding to mental health issues in the perinatal period.

Specialist perinatal services are vital because of the very negative consequences of perinatal mental health disorders for the mother, the baby, their relationship and that with the partner and other children. The specialist teams and mental health midwives work jointly to ensure that all women attending the maternity service will have information on positive mental health. Standard questions on mental health as well as physical health should be routinely asked of each woman attending both booking and review clinics. The Specialist Perinatal Mental Health Service has the responsibility for women with moderate to serious mental illnesses



Output

Staffing

During 2019, the National Programme for the implementation of Specialist Perinatal Mental Health Services focused on the recruitment of multidisciplinary teams in the 6 hub sites that is the three large maternity hospitals in Dublin as well as the maternity units/hospitals in Cork University Maternity Hospital, University Maternity Hospital Limerick and Galway University Hospital. Bespoke panels were created for positions such as Senior Psychologists, Senior Mental Health Social Workers and CNSMH nursing staff. The recruitment of mental health midwives in both the 6 hub and the 13 spoke sites in Ireland also continued with a number of national recruitment campaigns. Staff were provided with specific induction and training including training from Dr. Liz McDonald, Honorary Consultant in Perinatal Psychiatry, Clinical Lead for Perinatal Workforce Development at the Royal College of Psychiatry in London.



Specialist Perinatal Mental Health Multidisciplinary Team members attending training at the University of Limerick, December, 2019.



Hub and Spoke Model of Care - Training day, Ursula Nagle, PMH Midwife Rotunda Hospital, Fiona O'Riordan, National Programme Manager and Dr Deirdre Muller-Neff, Consultant Psychiatrist CUMH.

Supports available to frontline staff

New frontline staff working in Specialist Perinatal Mental Health Services are provided with specific induction and specialist training in line with their discipline and role within the multidisciplinary team. The National Programme also set up a National Oversight Implementation Group (NOIG) which consists of a psychiatrist from each hub site as well as a national nominee from each other discipline on the SPMH multidisciplinary team. The NOIG meet every two months and address such issues as recruitment, clinical activity, training needs, accommodation for teams and other relevant matters.

The Perinatal Mental Health App for Healthcare Staff

The Specialist Perinatal Healthcare App for healthcare staff was developed in 2019 and is designed to provide the latest information to assist all frontline staff in their roles, providing information on how to access services for women seeking information, advice and support for mental health problems in pregnancy and the first year post-partum. The app has now been downloaded by approximately 1,000 frontline healthcare staff who work in areas such as midwifery, public health nursing, psychology, community mental health teams as well as GPs and practice nurses.

For staff it hosts all the latest education and training information on Perinatal Mental Health available in an easily accessible format. The app is regularly updated with new content, weekly MCQ questions and information on news and events related to perinatal mental health services. Available at: <https://PMH.healthcarestaff.app>

Accommodation for Perinatal Mental Health Staff

The Specialist Perinatal Mental Health Model of Care is based on maternity networks as recommended in the NMS. This aligned specialist services to maternity hospitals/units in a hub and spoke format in 19 different sites (6 hub and 13 spoke sites). During 2019 the Rotunda Hospital provided the expanding perinatal mental health team with two modular units on site. The Coombe hospital also plans to provide 2 units and the National Maternity Hospital has provided additional accommodation in line with additional

perinatal mental health staff appointments. The three hub sites outside Dublin are currently working on accommodation solutions for their new perinatal mental health teams, in terms of both office accommodation and outpatient clinics in which to see patients with mental health problems in pregnancy. This must be based in the maternity hospital hub sites to ensure maximum accessibility and a seamless service for women.

The MOC set out three components of specialist perinatal mental health services, these are:

- Specialist mental health service to maternity units/hospitals
- Mental health midwife component
- Specialist inpatient mother and baby unit

Planning for Ireland’s first Mother and Baby Unit is currently underway and a joint business case is being developed between Mental Health Services in HSE CHO6, St. Vincent’s Hospital, Dublin and the National Maternity Hospital. Given the documented adverse effects of separating mothers from their babies, the provision of a mother and baby unit as a national tertiary unit is vital and it is hoped that a submission to HSE National Estates Management will take place during 2020.

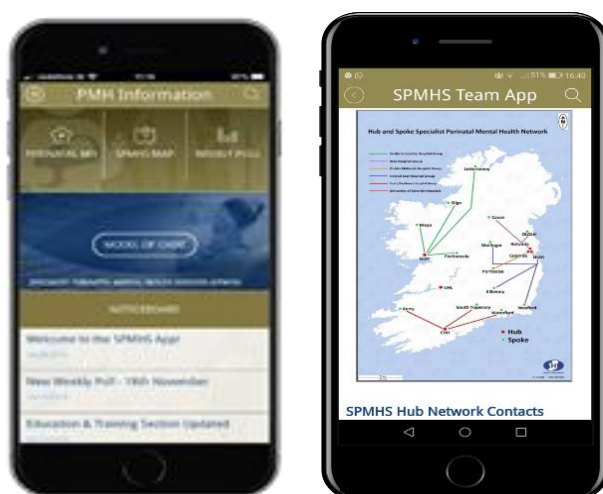
Patient Information

During 2019 a project, developed from the NOIG meetings, was initiated to develop a range of patient information leaflets for Specialist Perinatal Mental Health Services. These, when finalised, will cover a wide range of topics including: perinatal mental health tips, mental health problems in pregnancy, health and supports available, information for women with existing mental health problems, postnatal depression information, Perinatal OCD, Lithium in pregnancy, Valproate in women and girls who could get pregnant, Postpartum Psychosis, as well as Information for carers. An editorial sub group is being established and it is anticipated that the information leaflets will be available in early 2020. These will provide much needed advice to the public and support the awareness and importance of perinatal mental health for women and their families.

Patient Information Leaflets



Perinatal Mental Health App for Healthcare Staff



See: [www.https://pmh.healthcarestaff.app](https://pmh.healthcarestaff.app)

Feedback from Service Users

The December 2019 issue of Health Matters featured the Specialist Perinatal Mental Health Service at the University Maternity Hospital Limerick.

It reported that two years after its launch, women across the country have spoken about the transformative effects the Specialist Perinatal Mental Health model of care has had on their pregnancies and beyond. The article also covered how the Specialist Perinatal Mental Health Service is constantly striving to develop and improve the service at University Maternity Hospital Limerick by holding an innovative workshop event where women provided staff with vital feedback on their experiences to help inform future delivery of the service.



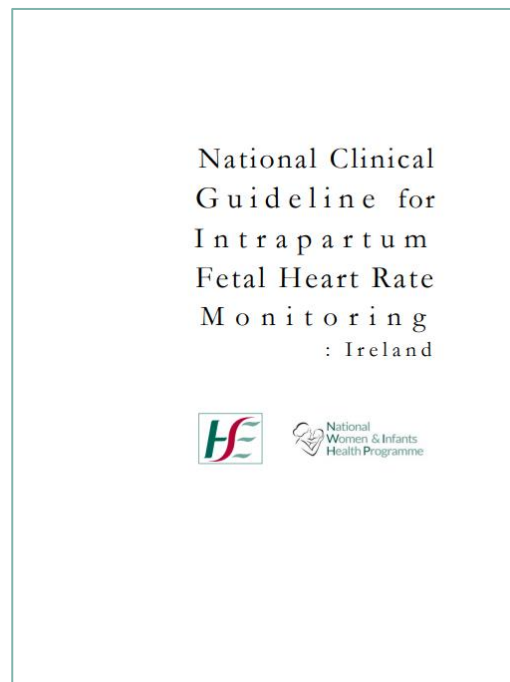
12. Revision of the National Clinical Guideline for: Intrapartum Fetal Heart Rate Monitoring Guideline

Overview/Context/Background

A multidisciplinary working group was formed in June 2018 to revise the Intrapartum Fetal Heart Rate Monitoring (FHRM) Guideline.

Key Deliverables/Outputs

The Group met once monthly until May 2019. A consultation version of the revised Guideline was circulated throughout the system. This process lasted for over two months and edits were made to the Guideline accordingly. The Guideline was published on 31st July 2019 with an information leaflet for expectant mothers and families. An earlier version of the leaflet was tested with three separate focus groups; two of expectant mothers and one mothers who had recently delivered their baby.



Objectives for 2020

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 2020 making adaptations as appropriate following feedback received post-publication.

The NWIHP would like to acknowledge the considerable time and work of the multidisciplinary Guideline Revision Group since 2018, and the considered feedback shared during the extensive consultation process between May and July of 2019.

13. Governance and Accountability

Maternity Safety Statements

Maternity Safety Statements (MSS) continue to be 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 including number of births, modes of delivery, major obstetric events and clinical incidences.

The MPSS is reviewed on a regular basis by the Programme and is discussed directly with the Maternity Networks as a standing agenda item at the maternity network meetings with the NWIHP.

Maternity Network Meeting

A key recommendation of the NMS 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 NWIHP 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.

The NWIHP met with the maternity networks on a regular basis throughout 2019 with an agreed agenda, looking at the implementation of the NMS and also at on-going quality and safety issues. These regular meetings are a key vehicle by which the NWIHP further develops its knowledge and insight as to the development and delivery of maternity services on the ground. The key opportunities and challenges facing service providers are highlighted, determining priorities and how best to proceed with the advancement of the NMS. The NWIHP holds the networks to account for funding and investment received to date. These engagements enable and support open and honest two way communication thereby further strengthening and developing the partnership approach between the NWIHP and the maternity networks.

While good progress was made in 2019 in the structure and engagement with maternity networks, there are still some hospital groups where the maternity networks are at a very early stage of development, and further work is required to have a consistent approach across all six hospital groups.

Parliamentary Affairs

During 2019, the NWIHP was assigned and responded to over 90 Parliamentary Questions and Representative Queries involving a wide range of maternity and gynaecology related patient services including provision of anomaly scanning services, maternity care pathways available, breast feeding support, workforce levels, endometriosis services, management of miscarriages, mesh surgery, non-

invasive perinatal testing, bereavement services, homebirth services, neonatal services and provision of termination services.

14. Colposcopy Baseline Assessment Report

Overview

In response to the increasing pressures that were being experienced by colposcopy units around the country on foot of the challenges in place in the Cervical Screening Programme, the National Clinical Director of the NWIHP was requested by the National Screening Service (NSS) to undertake an impact assessment exercise on all fifteen colposcopy units. This programme of work involved direct engagement with all fifteen units.

Site visits were undertaken to all fifteen colposcopy units by the NWIHP personnel between December 2018 and May 2019 with subsequent submissions and follow ups being managed remotely. These engagements primarily focused on reviewing and ascertaining the primary challenges that each unit was facing in the immediate term, whilst enabling initial discussions and assessments to be undertaken regarding the capacity of units to support a primary HPV based screening programme and management of the Department of Health commissioned Royal College of Obstetricians and Gynaecologists audit.

Output

The output of this exercise was a National Report, which was submitted by the NWIHP to the Cervical Screening Programme further to review and sign off by the individual 15 colposcopy units and Hospital Group executive and clinical management. Within this Report, a series of common issues and themes that were raised and identified by colposcopy clinical leads and their teams were highlighted by the NWIHP. Ten key recommendations and findings were identified, including:

- Requirement for common infrastructural standards for colposcopy units to be established and a programme of investment to be developed to enable units to work towards achieving these standards;
- A nurse centred model of delivery being recommend to the NSS for future development;
- The NSS to work directly with the National Medical Device Replacement Programme with a view to undertaking a joint review of equipment replacement needs and establishing a structured programme to manage replacement requirements over a defined period of time;
- Each colposcopy unit to be assigned a specific liaison / link person within the NSS and 6-monthly site visits to the individual units commence so as to support the rebuilding of key working relationships and communication structures;
- The availability and engagement of specialist cytopathology services should be reviewed with each colposcopy unit so as to ensure that the appropriate supports are in place to enable safe, quality clinical decisions; and

- The development of and investment in ambulatory gynaecology services are prioritised by the HSE so as to enable an effective screening colposcopy service and alternative appropriate management of clinical indicated referrals.

Additionally, focusing on the immediate term requirements of the units a detailed, costed investment programme regarding additional personnel required across the 15 units was identified the personnel requirements identified were additional consultant resources, nurse colposcopists, colposcopy nurses, administrative personnel and health care assistants.

In total an additional 62.4 WTE were identified and recommended across the spread of personnel resources above, with the full year cost of these additional posts identified at €4.56 revenue inclusive of pay and non-pay costs.

The Baseline Assessment National Report as developed by the NWIHP formed the basis of engagement between the HSE and the DoH as to the additional investment required in screening colposcopy units so as to ensure they were positioned to manage safely the increased workload that the screening services were experiencing.

Based on the recommendations and profiling exercises undertaken by the NWIHP, the Department of Health released an additional €2 million in revenue funding for colposcopy units in the latter half of 2019. This funding was utilised by the NSS and HSE Acute Operations to approve and support just under 30 additional WTE for screening colposcopy units in 2019.

Additionally within 2019, utilising in year time related saving and informed by a staged programme of investment developed by the NWIHP and the National Medical Device Replacement Programme, €1.3 million of the €2 million was targeted at supporting Phase One of a dedicated equipment replacement programme for colposcopy units in 2019.

Objectives for 2020

In relation to further work in this area, the NWIHP will continue to work with NSS and Acute Operations in terms of supporting the HSE in its continued engagement with the DoH regarding screening colposcopy units, particularly in relation to securing the further €2.56 million that was identified as required, and deploying Phase Two of the dedicated replacement programme using a similar funding model as heretofore.

Work in this area has also further informed and strengthened the NWIHP commitment to advocating for additional investment in gynaecology services, specifically ambulatory gynaecology services. It was abundantly clear during the course of this work programme, with clear consensus across all professionals, that it is simply not possible to have an effective screening colposcopy service in the absence of alternative pathways of gynaecology care for women presenting with clinical indications.

15. Royal College of Obstetricians and Gynaecologists (RCOG) Review

Overview

In May 2018, the Minister for Health commissioned an Independent Expert Panel Review Cervical Check to be carried out by the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK. Its purpose was to provide women who participated in CervicalCheck and developed invasive or microinvasive cervical cancer with independent clinical assurance about the timing of their diagnosis and treatment. There were 1,038 women or their next of kin in the review cohort.

DOH as commissioner of the RCOG Review, was responsible for strategic elements relating to its design and oversight. The DOH instructed the HSE to support the expert panel in completing its work, as per the Terms of Reference agreed between the DOH and RCOG. The DOH also delegated to the HSE the logistical support regarding the communication of the results to the women and families and to provide patient and staff supports to individuals impacted by the review.

Outputs

Arising from the on-going engagement with CervicalCheck in 2019, the Clinical Director of the NWIHP was appointed as joint lead of the HSE - RCOG Communication of Results team alongside the Deputy National Director, Acute Operations. The team was tasked with planning and implementing organisational arrangements for receiving and communicating the RCOG Review results to women and families.

During the course of the planning phase it was anticipated that as many as 400 meetings would be needed. In the context of the increased demand in colposcopy clinics over the preceding 12 months and to minimise the impact on the on-going provision of colposcopy services, a team of 10 retired gynaecologists, 22 senior nurses and 23 note takers were identified to assist with the communications process in addition to local clinicians.

To facilitate standardisation of the communication process across the 16 units an educational programme was designed and delivered in 5 locations in conjunction with the HSE Open Disclosure team. The educational programme focused on the principles of how to conduct an open disclosure/breaking bad news meeting as outlined in the HSE Open Disclosure Policy. Additional educational sessions were provided on a number of related areas including cytology, colposcopy and the principles of screening. The educational programme was devised and delivered by acknowledged experts and senior medical staff.

Patient engagement assisted with the design of the communication process and suggested offering women the choice of attending meetings irrespective of whether their results were discordant or concordant with their original smears. Advice was also sought as to how the meetings might be conducted in order to be of most benefit to the women and families. All meetings took place in a standardised and structured format.

Overall, 260 women chose to discuss their individual reports at a face to face meeting. These meetings were held in 35 locations over a four month period starting in September 2019. The majority of the meetings were conducted by the gynaecological and senior nurses that were external to the relevant

colposcopy unit. Although 90-120 minutes were set aside for each meeting most were concluded in a shorter period of time notwithstanding that the subject matter of these meetings was difficult and complex for the women and families.

Objectives for 2020

At the conclusion of these meetings and to ensure that key learning was captured from this process of engagement and open disclosure, a study on the patient's experience of the meetings is being planned to be undertaken during 2020.

16. Model of Care for Assisted Human Reproduction (AHR) Services

Overview

Late in 2018, at the request of the Department of Health, the NWIHP developed and submitted an examination and assessment of the potential scope of the model of care for assisted human reproduction (AHR) services. This examination and assessment, which was informed by the General Scheme of the Assisted Human Reproduction Bill 2017, was designed around the six maternity clinical networks being the basic service delivery structures upon and around which publically funded AHR services would be designed and built.

The requirement for a three staged care pathway, spanning primary care, secondary care maternity services and specialised tertiary maternity care services was identified with a view to ensuring that patients were cared for and managed at the lowest level of clinical intervention necessary whilst having access to more specialist services at defined and agreed triage and referral points based on clinical requirements and indications.

Outputs

In 2019, the NWIHP participated in a DoH AHR Project Groups to make policy recommendations on the Model of Care for publically funded infertility services in Ireland. The work of this Group included assessing the current level of public service provision and expertise in infertility management, reviewing potential pathways of development of public AHR service provision with hospital groups, reviewing required infrastructure and personnel, identifying the stages of development of a comprehensive infertility care pathway, examining the potential associated models of delivery in the short, medium and long term.

As part of this programme of work, the NWIHP engaged with each of the maternity networks, undertook a baseline assessment of the current level of provision of services in the tertiary maternity services, reviewed international guidelines and practice in this area, undertook a site visit to the publically funded and provided AHR infertility service in Northern Ireland and provided recommendations and advice to the Department as to how the development of this service should proceed, strongly advocating for a publically funded, publically provided model of AHR within Ireland.

On foot of the work of the Project Group, a Memorandum for Decision in relation to the Development of a Model of Care for Infertility was developed by the DoH Project Team for consideration by the Secretary General, the Chief Medical Officer and ultimately the Minister for Health in the Department of Health.

The resulting Model of Care for Infertility involves a Care pathway that is comprised of three stages:

- **Primary Care** – A patient’s GP providing the initial suite of services including initial counselling, defining the infertility issues, undertaking baseline investigations and reviewing lifestyle factors;
- **Secondary Care** – A Regional Fertility Hub services to be developed in each of the six maternity networks, which would be targeted at the medical and surgical management of infertility related issues as appropriate to secondary level, with it being estimated that 50- 70% of patients presenting could be managed successfully at this level of intervention; and
- **Tertiary Care** – Involves the provision of In Vitro Fertilisation (IVF) and other advanced AHR treatments. It was identified that these would be provided through the public health system in two to three National AHR Centres. The adoption of this publically funded, publically provided model would enable specialised expertise to be developed, maintained and built up within the public health system, thereby enabling the HSE and the DoH to be well positioned to manage and guide the provision of this rapidly evolving and complex field of medicine.

It was identified that the initial roll out of this Model of Care, Phase One, would focus on the development of regional infertility services at secondary level, specifically the implementation of the six recommended Regional Fertility Hubs.

Objectives for 2020

Based on the indicative funding that was notified to the NWIHP late in 2019 as potentially available in 2020 (€2 million), the NWIHP had proposed that Phase One should commence with the development of four regional hubs in The Rotunda Hospital, The Coombe Hospital, The National Maternity Hospital and Cork University Maternity Hospital in 2020, with the remaining two hubs to be based in Galway and Limerick coming on board in 2021.

17. Model of Care for Ambulatory Gynaecology

Overview

Gynaecology services are acknowledged and recognised by both the DoH and HSE as being a service area that continues to be under significant and growing pressure. Demand for gynaecology services is now consistently outstripping supply on a year to year basis, with increased waiting lists at national level being experienced across all service delivery areas i.e. outpatient, inpatient and day case.

In response to the challenges being experienced in this area, gynaecology was one of six clinical specialised areas, identified and prioritised within the public healthcare system in 2019 as requiring the development of a tailored service improvement plan. The NWIHP were requested by the DoH to undertake this work in the context of an overarching Model of Care for gynaecology services.

In developing a plan to increase the capacity in the area of general gynaecology, with the objective of reducing wait times for women seeking to access this service, the NWIHP were guided by the following principles:

- Management of women at an intervention level that meets their clinical needs;
- Embedding safe and appropriate clinical practices;
- Ensuring the cost-effective use of public resources; and
- Providing a sustainable and responsive service to the healthcare needs of women.

It was also recognised by the NWIHP, that the direction of travel for the improvement of general gynaecology services in the short to medium terms must be on establishing safe alternative patient pathways which redirect women away from the traditional GP referral to out-patient to diagnostic to day case / inpatient pathway and instead provides the care required in a more streamlined manner in less costly, more appropriate settings essentially shortening the care pathway for patients and enabling more effective and efficient use of resources.

This approach will not only benefit the cohort of women that can be managed in this manner, it also enables a downstream positive impact regarding gynaecology service provision to other women awaiting care; by means of releasing valuable gynaecology inpatient and day care beds and scarce gynaecology theatre resources.

Outputs

In responding to this service challenge and developing a strategic response to the significant challenges being experienced in general gynaecology services, NWIHP developed a model of care that targeted the development and deployment of ambulatory gynaecology clinics as a core component of general gynaecology services within the Irish public health service.

Ambulatory gynaecology services are one-stop, see and treat clinics. Internationally, these clinics have demonstrated improved patient safety and experience, minimising unnecessary hospital admissions and

providing timely gynaecology care to patients referred as urgent and non-urgent. Their standardised implementation will lead to more a fruitful expenditure of public money in line with best practice. Based on the experiences to date of the small number of such clinics present within the public health service, the NWIHP estimated that approximately 70% of general gynaecology referrals are suitable for management in an ambulatory setting. Management in this manner would alleviate pressures on acute inpatient and day care gynaecology services as a specific and significant cohort of women are treated in an alternative setting.

This pathway has been designed to ensure that:

- Patients are fast tracked to a “see and treat” gynaecology service with same day diagnostics.
- Results may be delivered on the same day to the patient.
- Patients identified with abnormal results/findings can be identified and referred on to the appropriate specialist care pathway e.g. gynaecology oncology services.
- Patients are managed by the right person in the right location.

Patients may present at an ambulatory clinic for a range of reasons including abnormal uterine bleeding, chronic pelvic pain, evaluation of adnexal mass, management of precursors to cervical cancer – lesions caused by HPV, vulval issues, sexual dysfunction etc.

In providing a one-stop, see and treat service, it is recommended by the NWIHP that ambulatory gynaecology clinics should be developed to provide a suite of investigations including haematology, pelvic ultrasound, diagnostic hysteroscopy and endometrial biopsy. On foot of the clinical finds of these investigations, ambulatory clinics should also provide a suite of treatments and minor procedures including cervical polypectomy, endometrial polypectomy and intrauterine device management.

Objectives for 2020

The establishment of ambulatory gynaecology clinics within hospital groups was identified as a priority requirement by the NWIHP. Working closely with the DoH, the NWIHP envisages a phased roll out of ambulatory gynaecology clinics around the country, commencing with at least three such units in 2020 in larger tertiary centres – namely the Rotunda Hospital, Cork University Maternity Hospital and Galway University Hospital.

18. Sexual Assault Treatment Units (SATU)

Overview

Sexual Assault Treatment Units (SATUs) in Ireland provide clinical, forensic and supportive care for those who have experienced sexual violence. There are six SATU units located in Dublin, Cork, Waterford, Mullingar, Galway and Letterkenny. In 2018, the Minister for Health, Simon Harris, commissioned a review of the SATUs. The Policy Review examined the policy efficacy of SATUs and identified a number of medium-term, short-term and two long-term action areas.

Actions identified include:

- Increasing and ring-fencing the SATU budget by 25%.
- Developing robust national oversight of this critical area of health service delivery.
- Supporting a more sustainable SATU workforce to ensure excellent care for vulnerable patients.
- Expanding the SATU service so that the longer-term emotional and social needs of patients are looked after as well as their immediate medical and forensic needs.

There has been significant progress achieved since the launch of the Policy Review in March 2019.

Outputs

Some key outputs for 2019 included:

- Appointment of Dr Maeve Eogan, Rotunda Hospital, as SATU National Clinical Lead.
- Agreement to implement structured and funded protected time for Clinical Directors in the six SATU units - Dublin, Mullingar, Galway, Cork, Donegal and Waterford - to provide necessary expertise and clinical leadership.
- Accountability for implementation of the Policy Review assigned to the NWIHP.
- Nine additional Forensic Nurse Examiners (FNEs) appointed to posts.
- Nine additional Forensic Medical Examiners (FMEs) completed training.
- 'Rapid responder' operating model under review and development – ensuring that staff can travel to a patient's nearest SATU if required, limiting the need for patients to travel to receive care.
- SATU Interagency study day held for those involved in SATU care provision.
- Local refurbishment projects undertaken to the physical environment of SATUs so as to improve patient experience.

The Policy Review recognised that there were immediate opportunities to make improvements in the physical environment of the six SATUs. Small but significant refurbishment works were undertaken to improve and upgrade the look and feel of each SATU with an aim to improve the experience of patients. Photo's below provided by the Mullingar SATU.

Before



After



“Having struggled the past ten years with uncomfortable chairs, and a busy clinical environment we felt that what the patients needed was to be cared for in an environment that maintained the forensic robustness essential to prevent any contamination of forensically valuable evidence and had an easy feeling about it. When patients come to us a lot of the time they may be cold, sore, tired and not feeling very well. We needed to help them.

We set about gathering together ideas from all the team and anyone who was using our services. Ideas were taken no matter how crazy with the only criteria was that it helped the patient. We put together a wish list and sent it off with our fingers crossed. We were very fortunate that funding was granted and we were able to redecorate.” **Nessa Gill –Forensic Nurse Examiner Mullingar**

Objectives for 2020

1.5 Governance & Management

The SATU Policy Review highlighted opportunities to improve the governance and management of SATUs nationally. As referenced earlier, a National Clinical Lead was appointed in 2019. Clinical Directors were also afforded protected time in each SATU. In 2020, the NWIHP will prioritise the appointment of a National Staffing and Operations Manager (NSOM) who will work as part of the SATU Network Management team alongside the National Clinical lead, Clinical Directors and NWIHP Business Manager.

1.6 Training

A tender will be conducted in 2020 to review the Nursing (Level 8) and post graduate diploma in Nursing (Level 9) programmes – Sexual Assault Forensic Examination (SAFE). The Aim of the review will be to examine and evaluate FNE training, to inform future training and practice.

1.7 Emotional Supports

To ensure staff feel supported and valued in their difficult roles and that the best standard of care is provided to patients accessing SATU service, a key focus in 2020 will be the continued introduction of high quality emotional supports for all staff (core and on-call).

1.8 Services

The Barnahus model – which is a child-friendly, interdisciplinary and multi-agency centre (Tusla, HSE, An Garda Síochána) for child victims and witnesses is currently being piloted virtually in Galway with outreach to Roscommon, Sligo and Leitrim. The project brings together forensic, protection, health, therapeutic and policing services for children and adolescents where sexual abuse is suspected. In 2020 this virtual model will be moved to a physical location by agreement with the various agencies and facilitated by HBS Estates. The Letterkenny SATU will also relocate to a new purpose built unit in early 2020. The 13th annual SATU Interagency Study day will also take place in 2020 and will be hosted by the Mullingar SATU.

19. Termination of Pregnancy Services

Overview

The Health (Regulation of Termination of Pregnancy) Act 2018, was signed into law by the President of Ireland on 20th December 2018 and broadens the circumstances in which termination of pregnancy (ToP) may be legally permitted in Ireland. Due to its ministerial priority, TOP services, as provided for under the new Act, went live on 1st January 2019 in community and acute care settings in Ireland.

The majority of terminations not exceeding nine weeks are provided by doctors within a community care setting. ‘Doctors within the community setting’ refers to general practitioners as well as doctors working within family planning and women’s’ health clinics. Terminations at 9-12 weeks gestation are provided within a hospital setting. Termination of pregnancy services can be accessed on a universal basis, free of charge.

There are a number of options for termination of pregnancy depending on the individual case. The care pathways are as follows:

- Medical termination of pregnancy (less than 9 weeks) **(community)**
- Medical termination of pregnancy in secondary care (less than 12 weeks) **(hospital)**
- Surgical termination of pregnancy (less than 12 weeks) **(hospital)**
- Termination of pregnancy (over 12 weeks) – maternal **(hospital)**
- Termination of pregnancy (over 12 weeks) – fetal **(hospital)**

The NWIHP under the governance of the Chief Clinical Officer, provides strategic direction and leadership for termination of pregnancy services. The National Women and Infants Health Programme works closely with Acute Operations and Community Operations to have oversight and find solutions to any strategic issues arising.

Key Outputs

1.1 Training

During the planning and initial implementation phases, ‘values clarification training’ was provided in a number of sites in conjunction with the World Health Organisation (WHO). The Institute of Obstetricians and Gynaecologists (IOG) has been a key stakeholder in the development and delivery of ToP services in Ireland. In 2019 the IOG was allocated funding to enable the following work to be undertaken in collaboration with the HSE:

- Design, development and delivery of a training curriculum in the area of termination of pregnancy; and
- The development and delivery of a structured review process of the suite of clinical guidance documents produced to date under the auspices of the Institute in relation to the provision of termination of pregnancy care in a range of clinical scenarios.

1.2 Clinical guidance and information materials

The following interim clinical guidance documents have been developed:

- Termination of pregnancy under 12 weeks (IOG)
- Risk to life or health of a pregnant woman in relation to termination of pregnancy (IOG)
- Pathway for management of fatal fetal anomalies and/or life limiting conditions diagnosed during pregnancy (IOG)
- Interim clinical support for termination of pregnancy in general practice (ICGP)

The HSE has further developed an initial national model of care for the provision of termination of pregnancy services.

1.3 Information and Counselling Services

An external provider was contracted to deliver an information and counselling phone service ‘MyOptions’ helpline. The service is available from 9am to 9pm Monday to Friday as well as Saturday 10am-2pm and is staffed by counsellors.

‘My Options’ is a first a point of contact for those seeking support and information or counselling for any pregnancy related queries. This includes those who wish to explore the options available to them in the event of an unplanned pregnancy and also those who wish to access termination of pregnancy services in Ireland where they meet the legislative requirements.

1.4 Availability of Services

As set out in the HSE’s Model of Care, the majority of services are being provided in the community setting. There is a good geographic spread of GPs taking part and the Well Woman and Irish Family Planning Association (IFPA) clinics are well established in the provision of services in the greater Dublin area.

ToP services are currently provided in 10 of the 19 maternity units/hospitals. All maternity hospitals are providing the following services:

- Managing complications arising from termination.
- Providing appropriate care and supervision for women following a diagnosis of fatal fetal abnormality, and referral to the appropriate tertiary unit.
- Providing appropriate care and supervision in cases where maternal health/life is at risk, and referral to the appropriate tertiary hospital, as appropriate.

Objectives for 2020

To support further implementation and the on-going provision of ToP services, a need has been identified for the appointment of a national clinical lead who will provide on-going clinical leadership and guidance. The post of national clinical lead for termination of pregnancy was advertised and interviewed for in 2019. The successful candidate will be appointed and formally take up post in January 2020. A clinical advisory forum will also be established to further support the roll out of termination of pregnancy services nationally.

Additional 2020 deliverables include:

- Site visits to all 19 units to support further service roll out
- Meetings held with community providers
- Review of clinical guidance documents
- Model of care amended as required
- Quality assurance mechanisms explored with Department of Health
- Development of a training programme for nurses and midwives
- Procurement for 'My Options' helpline completed and
- Working group established to review the management of the vulnerable patient across community and acute settings, peer support and mentoring and complications management

20. The Use of Uro-gynaecological Mesh in Surgical Procedures

Overview

In July of 2018, the DoH 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 NWIHP 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, 21st November 2018*, which contains 19 recommendations for which the HSE is responsible.

Outputs

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. Work on the 19 recommendations as set out by the CMO continued during the course of 2019 in this regard.

A key focus during the course of the year was establishing pathways for women who have reported complications from mesh surgery. The HSE established a dedicated email address, and updated our website with the contact details where women with concerns can go to find the appropriate pathway for care. As well as a national contact point within NWIHP, there were contact details provided for each hospital group. By the end of 2019, approximately 60 women are recorded as having made inquiries about access to care for mesh complications. These 60 women either made contact through the National Women and Infants Programme, or through a hospital group, and every effort has been made to ensure that where a woman made contact with both, she is only recorded once.

The HSE is very much focused on providing appropriate and timely multi-disciplinary care to women that have suffered from complications, following the insertion of mesh. To support this approach, significant work was undertaken in relation to the development of a National Mesh Complication Service in Ireland in

2019. Working with key stakeholders and service providers in this area, it was determined that two hospitals – Cork University Maternity Hospital and National Maternity Hospital – would be designated as specialist centres for mesh, where women with complications can be referred for treatment. This will be one national service delivered across two hospitals sites. It is planned that these centres in addition to providing a surgical service, will also be positioned to provide auxiliary services to women in the form of pain medicine services, pelvic floor physiotherapy and psychosexual counselling. The remit of this national service will be to provide tertiary support to women with post implant complications, post removal complications and women who will not benefit from additional surgery / removal.

To support the development of this national service in 2019, two trans-labial scanners were funded by NWIHP and are due to be delivered to CUMH and the National Maternity Hospital (NMH) in January 2020. Once the scanners in place, it is planned that an expert in trans-labial scanning from the UK will come over and train the consultants who will work in the specialist centres, in the optimal use for the new devices. This is an important and positive development for women who are currently presenting with complications.

Objectives for 2020

The NWIHP will continue leading on behalf of the HSE in relation to work programmes in this area. Specifically work will continue on developing and deploying the new National Mesh Complication Service working closely with CUMH and NMH, and drafting and finalising guidelines for the treatment of Stress Urinary Incontinence (SUI), Pelvic Organ prolapse (POP) and Mesh Complications, informed and guided by the National Clinical Effectiveness Committee (NCEC) standards to create guidelines specifically for the Irish women in the context of the Irish healthcare system.

21. Funding

Overview

The provision of maternity developmental funding €4.55m to the NWIHP in 2018 enabled the NWIHP 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. Funding provided to the NWIHP in 2019 in relation to maternity services was targeted at the full year costs of those posts approved in 2018 i.e. existing level service (ELS) funding which continued to be actively recruited into during the course of 2019.

Outputs

In 2019, the NWIHP continued to invest in once off projects and initiatives at local level, including supporting Sligo, Wexford and Waterford maternity services to progress their home-away-from-home delivery suite projects, enabling Drogheda to undertake a refurbishment programme of their midwifery led unit, investing in the acquisition of new and replacement maternity related equipment including ultrasound machines around the country and supporting the out-sourcing of specific services pending the training and recruitment of permanent personnel.

To support the implementation of the recommendations contained within the DoH Policy Review on SATUs, additional development funding of €560k was provided to the NWIHP specifically for this service. This funding in 2019 was utilised by the NWIHP to support the formal appointment of a National Clinical Lead for the SATU service, enable protected and structured time for the Clinical Leads at local level of the six SATUs in place, support local and national training initiatives, allow the introduction of emotional and psychological supports for front line providers and enable local level refurbishment projects of SATUs.

In relation to the provision of termination services, an additional €7 million developmental funding was provided to the HSE specifically to commence this service within the hospital sector in 2019. This funding, which was managed by the NWIHP, was utilised to support the appointment of a suite of additional personnel across the six maternity networks, so that the new termination services could be provided safely to women in need of same within existing maternity and gynaecology services.

The cohort of posts approved included additional consultant obstetrician and gynaecologists, staff nurses / midwives, clinical specialist nurses and midwives, health and social care professionals including medical social workers and ultrasonographers.

From within this envelope of funding, acute maternity and gynaecology sites and services were also supported to undertake local refurbishment programmes to support the commencement and delivery of the service and other once-off set up costs. This funding was also utilised to appoint a National Clinical Lead for the service and support the Institute of Obstetricians and Gynaecologists to design and implement robust training and professional competence supports for NCHDs and consultants in the area of termination of pregnancy services.

22. Summary

A significant amount of progress was made in 2019 in relation to the on-going implementation of the NMS and across the wide range of work programmes that the NWIHP is driving and leading on.

The key developments outlined in this report, such as the on-going development and strengthening of the six Maternity Networks, the significant inroads being made across all services regarding the development of the midwifery provided supported care pathway, the expansion of services available to women accessing maternity service including anomaly scanning services, perinatal mental health services, smoking cessation services, bereavement services, the focus and development of pathways of care for infertility and ambulatory gynaecology services, the roll out and delivery of termination of pregnancy services, the investment in screening colposcopy services, the strengthening of sexual assault and treatment units, the focus on quality and patient safety agendas by multiple key agencies and players at all levels of the service – all mark real progress in improving the provision of care to women.

As identified throughout the course of this Annual Report, the NWIHP working with its collaborators and partners throughout the system and with the support of the DoH, have identified a significant number of priorities for 2020, all targeted at continuing and building on the improvements underway to date. These priorities include

- Development of submission for 2020 Estimate Process informed and underpinned by the key findings and insights gained during the period of 2019;
- NNEAG will identify work streams which will continue the engagement with all stakeholders going forward and the appointment of a full time Project Lead
- Funding of 12 additional AMP posts to drive the implementation of the Model of Care and ensure that all maternity services had at least one AMP post in this regard.
- Support the provision of home-away-from-home facilities in a number of sites;
- Identify and support local initiatives that could be applicable to other services that promote midwifery care e.g. Hopscotch;
- Continue on developing and deploying the new National Mesh Complication Services and drafting and finalising guidelines for the treatment of SUI, POP and Mesh Complications, informed and guided by the NCEC standards to create guidelines specifically for the Irish women in the context of the Irish healthcare system;
- Promote and support the development and roll out of the National Patient Experience Survey;
- Roll out of the National Healthcare Communication Programme to maternity service providers;

- Work with NSS and Acute Operations in supporting the HSE in its continued engagement with the DoH regarding screening colposcopy units;
- Commence Phase One of the Model of Care for Infertility with the development of four Regional Fertility Hubs in The Rotunda Hospital, The Coombe Hospital, The National Maternity Hospital and Cork University Maternity Hospital in 2020
- Under the Nurture Program Launch the antenatal education standards, Commence delivery of an antenatal education curriculum for practitioners and Continue contributing to the mychild.ie website;
- IMIS will continue to be implemented on a monthly basis at the 19 maternity hospitals/units;
- Continue to support further implementation and the on-going provision of termination of pregnancy services;
- Improve the governance and management of SATUs nationally, review Nursing programmes to include training for Sexual Assault Forensic Examination (SAFE) and expand emotional support services;
- Rollout of the Ambulatory Gynaecology Model of Care

Appendix 1

Maternity Hospitals/Units in Ireland.

The 4 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 colocated maternity units are:

5. Cork University Maternity Hospital; colocated 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 2019

- 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
- National Health Service
- 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