Irish Maternity Indicator System (IMIS)

Revised version 1.2, January 2017

HSE Clinical Programme for Obstetrics and Gynaecology

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

OBSTETRICS AND GYNAECOLOGY

IMIS 2017, Version 1.2

The Irish Maternity Indicator System (IMIS) was introduced in July 2014 in all 19 maternity units. It was designed to capture and measure clinical maternity activities in a standardised way across all maternity units, providing timely (monthly) reports for hospital managers across a suite of metrics.

This revised version of the IMIS (version 1.2) contains the same 30 metrics as before and retains the same structure, i.e., data are shown for the month and year-to-date in the previous year and in the current year. This version includes three new metrics for serious obstetric events: **Miscarriage misdiagnosis**; **Primary postpartum haemorrhage**; and **Retained swabs** (see overleaf for a detailed discussion of these new metrics). The IMIS provides definitions, including revised definitions, for all metrics.

The IMIS is intended to be based entirely on data sourced directly from maternity units. Data are collected on a monthly basis and reviewed by senior managers within hospitals. Hospitals are encouraged to capture and record additional activities not included in the IMIS.

Annual cumulative data are sent to the Quality Assurance Programme on the Clinical Programme for Obstetrics and Gynaecology and the HSE Acute Hospitals Division and Quality Improvement Division.

Outputs to date

- IMIS 2104 National Report (March 2016)
- IMIS 2014 Hospital reports for all 19 hospitals (March 2016)
- IMIS 2015 National Report (August 2016)
- IMIS 2015 Hospital Reports for all 19 hospitals (November 2016)
- IMIS 2015 Hospital Group Reports (December 2016)[1]
- The IMIS is aligned with the Maternity Patient Safety Statements.

The continuing development of the IMIS is consistent with the National Maternity Strategy 2016. We thank everyone who has contributed to the development of the IMIS.

Dr Léan McMahon, IMIS Project Manager
Martin McNicholl, Programme Manager, Clinical Programme for Obstetrics and Gynaecology
Professor Michael Turner, Clinical Lead, Clinical Programme for Obstetrics and Gynaecology

January 2017

[1] At the time of writing, the IMIS Hospital Group reports are not yet disseminated – awaiting consent from maternity hospitals.

IMIS 2017, New Metrics:

The IMIS 2017 contains three new metrics for serious obstetric events. The definitions, rationale, and relevant considerations for QA Officers around data collection of these new metrics are outlined here:

1) **Miscarriage misdiagnosis**, Metric #26

Definition: Number of women diagnosed during the current month with a spontaneous miscarriage when a subsequent ultrasound confirms an ongoing pregnancy.

Rationale: When ultrasounds to diagnose miscarriage are inaccurate, healthy pregnancies may receive unnecessary intervention and may be terminated unnecessarily.

Considerations:

- Miscarriage misdiagnosis usually occurs early in the first trimester.
- May occur if ultrasound criteria set out in the national clinical guidelines are not met.
- More likely to occur if clinical staff are inadequately trained and/or if ultrasound machines are technically substandard.
- Cases should be communicated to a Consultant obstetrician and gynaecologist, and should be notified to the State Claims Agency, Clinical Indemnity Scheme.

2) Primary postpartum haemorrhage, Metric #27

Definition: Number of women during the current month with loss of 500ml or more of blood within the first 24 hours following a vaginal delivery (do *not* count postpartum haemorrhage following a Caesarean section).

Rationale: PPH is a leading cause of maternal mortality.

Considerations:

- Counting both minor and major PPH reduces uncertainty around arbitrary cut-off points (e.g. 500ml).
- Restricting the metric to primary postpartum haemorrhage only (i.e., within 24 hours of vaginal delivery) reduces problems around capturing women who may be readmitted post-natally with postpartum haemorrhage.

3) **Retained swabs,** Metric #28

Definition: Number of women during the current month who have a swab retained unintentionally in the vagina after a vaginal delivery.

Rationale: Retained swabs are a source of maternal morbidity, including pyrexia, infection, pain, secondary post-partum haemorrhage, and psychological problems.

Considerations:

- Cases of retained swabs may present before the woman is discharged home postpartum or they may not present until after hospital discharge.
- In the unlikely event that a retained swab is discovered in a different hospital to that where the woman delivered, it should be reported back to the first hospital and recorded by that hospital.
- Cases of retained swabs are unusual and should be notified to the State Claims Agency, Clinical Indemnity Scheme.

IMIS: Irish Maternity Indicator System

Version 1.2, January 2017

HOSPITAL NAME: _____

MONTH / YEAR: _____ / _____

		Previous year		Current year	
		Month	Year-to-date	Month	Year-to-date
HOSPITAL MANAGEMENT ACTIVITIES					
1.	Mothers delivered ≥ 500g (n)				
2.	Multiple births (n)				
3.	Total nulliparous women (n)				
4.	Total multiparous women (n)				
5.	EPAU first visits (n)				
6.	Maternal transfers to Level 2/Level 3 care (n)				
7.	Maternal deaths (n)				
8.	Babies delivered ≥ 500g (n)				
9.	Perinatal deaths – Total (n)				
10.	Perinatal deaths ≥ 2.5kg without a congenital anomaly (n)				
NEONATAL METRICS					
11.	Neonatal encephalopathy (n)				
12.	Brachial plexus palsy (n)				
13.	Whole body neonatal cooling (n)				
14.	In-utero transfers admitted (n)				
15.	In-utero transfers sent out (n)				
LABORATORY METRICS					
16.	Maternal bacteraemia (n)				
17.	Early-onset neonatal bacteraemia (n)				
18.	Obstetric blood transfusions (n)				
SERIOUS OBSTETRIC EVENTS					
19.	Ectopic pregnancy (n)				
20.	Eclampsia (n)				
21.	Uterine rupture (n)				
22.	Peripartum hysterectomy (n)				
23.	Pulmonary embolism (n)				
24.	Perineal tears (3rd and/or 4th degree) (n)				
25.	Postpartum neuropathy (n)				
26.	**NEW!** Miscarriage misdiagnosis (n)				
27.	**NEW!** Primary Postpartum haemorrhage (n)				
28.	**NEW!** Retained swabs (n)				
DELIVERIES					
29.	General anaesthetic for Caesarean sections (n)				
30.	Labour epidurals (n)				
31.	Operative vaginal deliveries (OVD) – Total (n)				
	31a. OVD among nulliparous women (n)				
	31b. OVD among multiparous women (n)				
32.	Inductions of labour (IoL) – Total (n)				
	32a. IoL among nulliparous women (n)				
	32b. IoL among multiparous women (n)				
33.	Caesarean sections (CS) – Total (n)				
	33a. CS among nulliparous women (n)				
	33b. CS among multiparous women (n)				

IMIS Technical Notes

1. The IMIS is based entirely on data sourced directly from maternity units. Do not source data from national datasets, such as the Hospital In-Patient Enquiry (HIPE).
2. The IMIS is intended for **within-hospital use**: the data will be collected within the hospital and reviewed by hospital senior managers.
3. The reporting period for the IMIS is the calendar month, i.e., activities occurring between the first and last days of the month, inclusive, irrespective of admission or discharge dates.
4. Data: All data to be recorded as raw numbers (not percentages or rates).

   Hospital Management Activities should be sourced from hospital registers, birth notification forms, and IT systems.

   Laboratory Metrics should be sourced from Hospital Laboratories.

   Neonatal Metrics should be sourced from Neonatology/NICU Registers.

   Deliveries require breaking out by nulliparous and multiparous women.
5. The IMIS data are partly modelled on agreed datasets reported in maternity hospitals in Dublin and Cork, incorporating recommendations from the Clinical Programmes for Anaesthesia, Paediatrics, and Neonatology.
6. Where appropriate, the definitions align with the National Perinatal Reporting System, World Health Organisation, the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), and the Australian Classification of Health Interventions (ACHI).
7. The IMIS is intended to be completed using a combination of hospital IT systems and 'paper' registers. In future, it should be possible to generate IMIS reports using the planned Maternal and Newborn Clinical Management System (MN-CMS).
8. It is permitted to make changes to the monthly IMIS after it has been sent to senior managers. All changes should be updated on the hospital's files and the amended data should be recorded in the cumulative 'year-to-date' data. The amended data should be recorded in the annual data submitted to the Programme for Obstetrics and Gynaecology and National Women and Infants Health Programme.
9. The QA Officer should retain the original hard data records that are used to populate the monthly and annual IMIS reports (including amended versions). All data and IMIS reports should be stored securely within the hospital.

For further information:

For further information or assistance, please contact the Head of the National Women and Infants Health Programme.

IMIS Implementation Guidelines

1. The IMIS is designed to capture and measure clinicial activities in the maternity unit. It is intended for within-hospital use: the data will be collected within the hospital, by hospital staff, and reviewed by senior hospital managers.
2. The IMIS is based entirely on data sourced directly from maternity units.
3. Monthly completion of the IMIS is mandatory for the 19 maternity units.
4. The IMIS is approved by the National Implementation Group HSE/HIQA Maternity Services Investigations and is aligned with national recommendations in the Investigation Report of the HSE National Incident Management Team (2012); HIQA Investigation Report (2012); Report of Chief Medical Officer on Perinatal Deaths 2006-date (February 2014), Safety Incident Management Policy (June 2014), Review by Dr Peter Boylan (June 2015); and the National Maternity Strategy 2016-2026.
5. The Quality Assurance (QA) Officers in all 19 maternity units were nominated to work part-time on implementing the IMIS; the QA Officer should have access to hospital data files and should be accustomed to dealing with data within the hospital.

Monthly data collection and reporting of the IMIS:

6. The reporting period is the calendar month (i.e., from first to last day of the month).
7. The monthly report should be completed by the 20th day of the following month.
8. The QA Officer should send the monthly IMIS report to the following senior managers in the hospital:
   - Chief Executive Officer or Master
   - Clinical Director(s), as appropriate
   - Director of Nursing and Midwifery
9. The senior managers should review the monthly IMIS. If they have concerns arising from the IMIS, these should be discussed with the clinical staff and, if appropriate, reported to the Hospital Board or equivalent. In the event of serious concerns arising with national implications, these should be reported to the HSE Acute Hospitals Division.

Annual reporting of the IMIS:

10. The annual IMIS data should be completed by the **end of February** of the following year [Note: This is a change from Version 1.1).
11. The QA Officer should send the annual IMIS data to the following people:
    a) Senior managers of the hospital (as above)
    b) Project Manager of the Clinical Programme for Obstetrics and Gynaecology
    c) Head of the National Women and Infants Health Programme
    d) Heads of the HSE Acute Hospitals Division and the Quality Assurance Division
12. The Programme for Obstetrics and Gynaecology will check and verify annual data in collaboration with the individual hospitals.
13. The Programme for Obstetrics and Gynaecology will prepare annual national reports and disseminate to all hospitals and to other relevant organisations (e.g. HSE, the Department of Health, the Health Information and Quality Authority). The Programme will also prepare individual hospital-level reports for hospital senior managers and QA Officers only. The Programme will prepare Hospital Group level reports (dissemination will be subject to consent from individual hospitals).
14. If the senior managers of the hospitals have concerns arising from the annual IMIS data, these should be discussed and escalated as above.
15. Annual reviews of the IMIS format will be conducted by the National Women and Infants Health Programme.

Data Definitions

Metric	Definition
HOSPITAL MANAGEMENT ACTIVITIES	
1. Mothers delivered ≥ 500g	Number of women delivering a baby weighing 500g or more.
2. Multiple births	Number of multiple births, based on the number of women with multiple births (not the number of babies delivered by mothers with multiple pregnancies) occurring during the current month. A multiple birth results when more than one baby is born from a single pregnancy. *National Clinical Guideline:* Management of Multiple Pregnancy (June 2012)
3. Total nulliparous women	Number of deliveries to women who have never had a previous pregnancy resulting in a live birth or stillbirth (≥ 500g). *(Reference: NPRS).*
4. Total multiparous women	Number of deliveries to women who have had at least one previous pregnancy resulting in a live birth or stillbirth (≥ 500g) occurring during the current month. *(Reference: NPRS).*
5. EPAU First visits	Number of first visits to the Early Pregnancy Assessment Unit occurring during the current month (do NOT count the number of combined first and return visits).
6. Maternal transfers to Level 2/Level 3 care	Number of women transferred to Level 2 care (i.e., Critical Care Unit) and/or Level 3 care (i.e., Intensive Care Unit) either within the hospital OR to another hospital/unit during the current month. Serious obstetric events that require women to be transferred should be reported by the hospital where she gave birth and NOT the hospital to which she was transferred and where she received treatment for the problem. There is no gestation parameter on this metric – it may include transfers from early pregnancy through post-natal re-admissions.
7. Maternal deaths	Number of deaths of women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes occurring during the current month *(Reference: WHO (2014). Trends in maternal mortality: 2009-2013).*
8. Total live births ≥500g	Number of live births and stillbirths weighing greater than or equal to 500 grams (in accordance with WHO guidelines), occurring during the current month. A live birth is defined as the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached (WHO; NPRS).
9. Perinatal deaths - Total	Number of deaths, including stillbirths and early neonatal deaths (from delivery to six completed days), occurring during the current month. A stillbirth in this report refers to the death of a fetus weighing ≥ 500g; an early neonatal death refers to the death of a live born infant during the first seven days of life. (This metric is not adjusted to exclude congenital anomalies.) *(WHO; NPRS).* *National Clinical Guidelines:* – Investigation and Management of Late Fetal Intrauterine Death and Stillbirth (October 2011) – Management of Early Pregnancy Miscarriage (April 2012) – Management of Second Trimester Miscarriage (July 2014)
10. Perinatal deaths ≥ 2.5kg without a congenital anomaly	Number of perinatal deaths (stillbirths and early neonatal deaths) weighing 2.5kg or more without a congenital anomaly occurring during the current month. Congenital anomalies are physiological or structural abnormalities that develop at or before birth and are present at the time of birth. *(Reference: Diseases/conditions in ICD-10, Chapter XVII, Congenital Malformations, Deformities and Chromosomal Abnormalities (Q00.0-Q99.9)).*

Metric	Definition
NEONATAL METRICS	
11. Neonatal encephalopathy	All infants ≥ 35 weeks gestation who during the first week of life have: • Either seizures alone, or • Signs of Neonatal Encephalopathy which is defined in clinical findings in 3 or more of the following domains: - Level of consciousness - Spontaneous activity when awake or aroused - Posture - Tone - Primitive reflexes - Automonic system Include inborn babies only (exclude outborn babies transferred in from another maternity unit). Note: Neonatal encephalopathy embraces Hypoxic Ischaemic encephalopathy (HIE). HIE is the most common cause of neonatal encephalopathy, but not all encephalopathy has a hypoxic ischaemic aetiology. *(Reference: NMH Annual Clinical Report, 2013).*
12. Brachial plexus palsy	Number of obstetric brachial plexus palsies (BPP), either transient or permanent, diagnosed during the current birth episode. *(Reference: ICD-10-AM P14.3, Other brachial plexus birth trauma.)* Obstetric BPP refers to loss of movement or weakness of the arm resulting from damage to the brachial plexus nerve network, which may occur from mechanical injury involving should dystocia during difficult childbirth. May include Erb's Palsy, Klumpke's Palsy, and total plexus injury.
13. Whole body neonatal cooling	Refers to active cooling (not passive) procedure administered during the current birth episode as a treatment for Hypoxic Ischemic Encephalopathy (HIE). Whole body neonatal cooling is only conducted in the four large maternity hospitals in Dublin and Cork. Eligible infants: Term infants (≥37 weeks) admitted at <6 hours of age to NICU with Birth Asphyxia or Depression. Include hospitals' own cases AND those transferred in from other units.
14. In-utero transfers admitted	Women with fetus in utero admitted into the hospital after being transferred from another hospital *in the fetal interest*, during the current birth episode.
15. In-utero transfers sent out	Number of women with fetus in utero who were transferred out of the hospital to another hospital *in the fetal interest,* during the current birth episode.

Metric	Definition
LABORATORY METRICS	
16. Maternal bacteraemia	Diagnosis of bacteraemia is based on laboratory definition only and does not include clinical indications. Diagnosis of bacteraemia is based on ONE positive blood culture for a recognised bacterial pathogen (e.g. *Staphylococcus aureus, Escherichia coli*). If any doubt regarding what constitutes a recognised bacterial pathogen, please discuss with Microbiology in your hospital. Exclude cases of blood culture contamination (e.g. skin contaminants). Cases should be defined as 'maternal' bacteraemia if the positive blood culture is taken at any time during pregnancy or within 42 days of the end of pregnancy. *(Reference: European Centre for Disease Prevention and Control. 2012. Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute care hospitals.' Technical document, protocol version 4.3, full-scale survey codebook. Stockholm: ECDC. Page 47. www.ecdc.europa.eu).* *National Clinical Guideline:* Bacterial Infections Specific to Pregnancy (February 2015)
17. Early-onset neonatal bacteraemia	For the purposes of the IMIS, diagnosis of bacteraemia refers to early-onset clinically significant bacteraemia in neonates (defined as bacteraemia at <72 hours of age) based on a laboratory definition of bacteraemia. Diagnosis of bacteraemia is based on ONE positive blood culture for a recognised bacterial pathogen. This would include Group B Streptococcus, E.coli, S.aureus, and any other organisms considered clinically significant by the consultant microbiologist. It would exclude contaminants such as Coagulase negative Staphylococci and Streptococcus viridians. If any doubt regarding what constitutes a recognised bacterial pathogen, please discuss with the consultant microbiologist in your hospital. For the purposes of the IMIS, the definition of neonatal bacteraemia does not include recognised pathogens cultured from cerebrospinal fluid. Exclude cases of blood culture contamination (e.g. skin contaminants). For this metric, neonates are defined as <72 hours of age. *(Reference: European Centre for Disease Prevention and Control. 2012. Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute care hospitals.' Technical document, protocol version 4.3, full-scale survey codebook. Stockholm: ECDC. Pages 47; 62. www.ecdc.europa.eu).*
18. Obstetric blood transfusions	Number of obstetric patients who receive one or more units of blood components/products (including red cells, plasma, platelets, etc.), not including clotting factors or recombinant products. Report number of obstetric patients receiving blood transfusions only (exclude gynaecology patients); 'obstetric' is defined as from the time of diagnosis of pregnancy (based on a positive pregnancy test). Such cases are rare. Count number of cases based on the general principle of hospital of delivery. In cases of ectopic pregnancy, count cases based on the hospital where women are treated for ectopic pregnancy. If a patient is transfused twice during her hospital stay, count her as n=1 transfusion and count her on the date when she received the first transfusion.

Metric	Definition
SERIOUS OBSTETRIC EVENTS	
19. Ectopic pregnancy	Number of women diagnosed during the current month with an ectopic pregnancy, including abdominal pregnancy, tubal pregnancy, ovarian pregnancy, and other/unspecified pregnancy. *(Reference: ICD-10-AM O00.0, O00.1, O00.2, O00.8, O00.9).* Do not source data on ectopic pregnancies from the HIPE. *NCG:* The Diagnosis and Management of Ectopic Pregnancy (November 2014) Ultrasound Diagnosis of Early Pregnancy Loss (December 2010, currently under review)
20. Eclampsia	Number of women diagnosed during the current month with eclampsia during any antenatal hospital event or at delivery, including eclampsia in pregnancy, in labour, in the puerperium, and eclampsia unspecified as to time period. Excludes severe pre-eclampsia. *(Reference: ICD-10-AM O15.0, O15.1, O15.2, O15.9).* *NCG:* The Diagnosis and Management of Pre-Eclampsia and Eclampsia (June 2016)
21. Uterine rupture	Number of women diagnosed during the current month with rupture of uterus before onset of labour or during labour, including cases that may not be diagnosed until after delivery. *(Reference: ICD-10-AM O71.0, O71.1.)*
22. Peripartum hysterectomy	Number of hysterectomy procedures completed during the current month, usually following a Caesarean section, including hysterectomies performed during pregnancy and/or procedures within seven completed days after delivery. *(Reference: ACHI Procedure Blocks 1268, 1269)*
23. Obstetric pulmonary embolism	Number of women diagnosed during the current month with obstetric pulmonary embolism, including pulmonary emboli in pregnancy and/or the puerperium. Exclude embolism complicating abortion or ectopic or molar pregnancy. *(Reference: ICD-10-AM O88.2)* *NCG:* Venous Thromboprophylaxis in Pregnancy (February 2015)
24. Perineal tears (3rd and/or 4th degree)	Numbers of third-degree and/or fourth-degree perineal lacerations diagnosed during the current month, including tears in the vaginal tissue, perineal skin, and perineal muscles that extend into the anal sphincter and/or go through the anal sphincter and the tissue underneath it. *(Reference: ICD-10-AM O70.2, O70.3)* *NCG:* Management of Obstetric Anal Sphincter Injury (April 2102)
25. Postpartum neuropathy	Number of women diagnosed during the current month with persistent (24-48 hours) partial lower limb or body weakness or numbness causing patient distress or loss of function. Related terms include postpartum palsy or lesion of femoral nerve.
NEW! 26. Miscarriage misdiagnosis	Number of women diagnosed during the current month with a spontaneous miscarriage and a subsequent ultrasound confirms an ongoing pregnancy. *NCG:* - Ultrasound Diagnosis of Early Pregnancy Miscarriage (April 2012) - Management of Early Pregnancy Miscarriage (April 2012)
NEW! 27. Primary Postpartum haemorrhage	Number of women during the current month with loss of 500ml or more of blood within the first 24 hours following a vaginal delivery (do *not* count postpartum haemorrhage (PPH) following Caesarean section). Count minor PPH (500-1,000ml) and major PPH (>1,000ml, including moderate (1,000-2,000ml) and severe (>2,000ml)). Do not count secondary PPH, i.e., abnormal/excessive bleeding from the birth canal between 24 hours and 12 weeks post-natally. *NCG:* Prevention and Management of Primary Postpartum Haemorrhage (October 2012)
NEW! 28. Retained swabs	Number of women during the current month who have had a swab (for cleansing and to absorb blood and other fluids) retained unintentionally in the vagina after a vaginal delivery.

Metric	Definition
DELIVERIES	
29. General Anaesthetic for Caesarean sections	Number of women during the current month who underwent a Caesarean section and were administered a general anaesthetic (GA), including primary GA and also conversion to GA from regional anaesthetic (epidural or spinal).
30. Labour epidurals	Number of women for whom labour epidurals were administered during the current month, including Neuraxial block during labour and Neuraxial block during labour and delivery procedure. *(Reference: ACHI Procedure Codes 92506-xx, 92507-xx.)*
31. Operative vaginal deliveries (OVD)	Number of women undergoing operative vaginal delivery, or instrumental delivery, including forceps delivery and vacuum extraction. Include: Low forceps delivery, mid-cavity forceps delivery, high forceps delivery, forceps rotation of fetal head, and forceps rotation of fetal head with delivery. Also includes assisted breech delivery with forceps to after-coming head and breech extraction with forceps to after-coming head. Exclude: Failed forceps and failed vacuum extraction. *(Reference: ACHI Procedure Block 1337 and Procedure codes 90469-00, 90470-02, 90470-04.)*
32. Inductions of labour (IoL)	Number of women during the current month undergoing induction of labour, Including medical induction of labour, oxytocin; medical induction of labour, prostaglandin; other medical induction of labour. Include surgical induction of labour by artificial rupture of membranes; other surgical induction of labour; and synchronous medical and surgical induction of labour. *(Reference: ACHI Procedure Block 1334.)* *NCG: Oxytocin to Accelerate or Induce Labour (April 2016)*
33. Caesarean sections (CS)	Number of women during the current month giving birth by Caesarean section, including elective classical Caesarean section, emergency classical Caesarean section, elective lower segment Caesarean section, and emergency lower segment, Caesarean section *(Reference: ACHI Procedure Block 1340.)* NCG: Delivery After Previous Caesarean Section (October 2011)

Appendix

1. **Recommendations addressed by the Quality Assurance Subgroup**

   HIQA Investigation Report (2013),[2] recommendations relating to 'use of information':

   'The HSE and key stakeholders should agree and implement effective arrangements for consistent, comprehensive national data collection for maternity services in order to provide assurance about the quality and safety of maternity services. This should include the development of an agreed and defined dataset and standardised data definitions to support performance monitoring, evaluation and management of key patient outcome and experience indicators.' (Statutory recommendation, N16)

   'The arrangements for collecting, reviewing and reporting maternal morbidity and mortality should be reviewed by the HSE to facilitate national and international benchmarking for improved learning and safety in the provision of maternity services. This should include a formal process for the implementation of recommendations of the Confidential Maternal Death Enquiries.' (Statutory recommendation, N17)

   HSE Investigation Report (2013),[3] Incidental Factor 1:

   'The review team recommends consideration of a National Quality Assurance Programme of Obstetrics and Gynaecology as an initial step to maintain confidence amongst patients/services users, staff, the public administrators and regulators and to put into place safety systems and interventions before a catastrophe happens. Monthly workloads, clinical outcomes, and adverse incidents should be monitored by using a dashboard to include green, amber and red signals to warn of the possibilities of impending problems.'

2. **QA Programme Lead:** Professor Michael J. Turner

   QA Programme Manager: Mr Martin McNicholl

   QA Project Manager: Dr Léan E. McMahon

3. **Membership of QA Subgroup**

   Ms June Boulger, National Lead, HSE Service User Involvement National Advocacy Unit
   Ms Deirdre Carey, Statistician, HSE
   Dr Howard Johnson, HSE Health Intelligence Unit
   Ms Aoife Lawton, HSE Systems Librarian
   Dr John Loughrey, Consultant Anaesthetist, Rotunda Hospital
   Dr Bob McDonnell, HSE Health Intelligence Unit
   Mr Hugh Magee, Senior Statistician, Department of Health (retired August 2014)
   Mr Alan Cahill, Senior Statistician, Department of Health (since September 2014)
   Dr Jennifer Martin, National Lead for Information and Analysis, HSE Quality Improvement Division
   Ms Anne Gallen, Director of Nursing & Midwifery Planning and Development Unit and National Lead on Nursing and Midwifery Metrics (Since September 2014)

2 HIQA Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar, 7 October 2013.

3 HSE National Incident Management Team Investigation of Incident 50278 from time of patient's self-referral to hospital on 21 October 2012 to patient's death on 28 October 2012.

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