Oversight Group for the Implementation of Recommendations in the HIQA Investigation Report on Portlaoise Hospital
13th Meeting – Thursday 14th July, 2016

Report of Meeting

Present

Dr Tony Holohan(Chair)	Chief Medical Officer
Dr Kathleen Mac Lellan	Director of Patient Safety and Clinical Effectiveness
Joan Regan	Acute Hospitals Division
Sheila O'Connor	Patient Focus

Apologies

Dr Siobhan O'Halloran	Chief Nursing Officer
Tracey Conroy	Assistant Secretary, Acute Hospitals Division
Liam Woods	Acute Hospitals Division, HSE

In Attendance

Angela Fitzgerald	Acute Hospitals Division, HSE
Eileen Ruddin	Acute Hospitals Division, HSE

Admin Support

David Keating	Patient Safety Unit

1. The minutes of the meeting on 30th June 2016 were agreed, with a small correction to point 3 f).

2. The 9th Report from the Oversight Group covering the period to 31st May, 2016 was submitted to the Minister on 4th July. This report was circulated to the Group.

3. The Oversight Group reviewed the Implementation Plan Report No 11, covering the period to 30th June 2016. The Group concentrated on and discussed those actions that were indicating a "minor challenge" to being delivered by the target date or had passed their target date.

    a) **Recommendation 1**: Dr Kathleen Mac Lellan gave an update on the establishment of a Patient Advocacy Service.

    b) **Recommendation 5**: Eileen Ruddin noted that interviews for Director of Midwifery posts had concluded and a number of offers had been made to the successful candidates.

    c) **Recommendations 6[1] and 7d**: The HSE had forwarded a report, "Key Risk Concerns in the Context of the HIQA Portloaise Report" shortly before the meeting. The report provides an overview for each Hospital

[1] A clearly defined, agreed, resourced and published model of clinical service delivery for each Hospital within the group. This must be supported by clearly defined, agreed and documented patient care pathways to ensure that patients are managed in or transferred to the most appropriate Hospital.

Group of its risks and associated mitigation strategies as they relate to the HIQA report. The report will now be considered by the Oversight Group.

Angela Fitzgerald also undertook to revert immediately with proposed additional text on Recommendation 6 to ensure its full implementation.

d) **Milestones 6.13 and 6.14**: HSE had forwarded a note on the development of obstetric networks shortly before the meeting. The note will now be considered by the Oversight Group.

e) **Milestone 6.16-6.18**: An issue related to the proposed reporting relationships for the required posts remains under consideration.

f) **Milestones 6.22-6.24**: Dr. Mac Lellan recalled the need for all maternity hospitals to publish full Maternity Patient Safety Statements each month. HSE were in full agreement and undertook to raise the issue with any hospitals which were failing to do so.

HSE had forwarded the Terms of Reference of the group set up to monitor the MPSS process. They will now be considered by the Oversight Group.

g) **Milestone 6.27**: HSE had forwarded a draft Hospital Patient Safety Statement in advance of the meeting. It will now be considered by the Oversight Group.

Dr. Mac Lellan noted that a number of metrics previously identified as worthy of inclusion, including pressure ulcers, staffing, DVT, UTI and Emergency Department waiting time, were not present.

It was agreed that a governance group similar to that for the MPSS process would be established and that this group would agree the metrics for the final template.

h) **Milestone 6.31**: Eileen Rudin informed that all hospitals had been advised of the required clinical audit guidelines; HSE will shortly be conducting an assurance process to confirm that a feedback and governance process is in place.

Dr Holohan noted the importance of having an appropriate process in place for occasions when an audit found issues of concern. Dr Mac Lellan noted this required for NOCA audits and for the information of the group informed of her understanding that a meeting is scheduled between NOCA and the HSE Acute Hospital Division.

i) **Milestone 6.42**: A meeting with Angela Fitzgerald, Eileen Rudin and Dr Kathleen Mac Lellan had been held to discuss the draft HSE business case for the patient safety culture survey. HSE are continuing to refine the business case, including where the overall concept will be situated in the wider QPS environment. The need for the survey to be integrated with associated elements of work was noted.

j) **Milestone 6.51:** HSE had circulated a document setting out current QPS staffing and additional future resources in advance of the meeting. Consideration of QPS capacity and its relationship to the wider healthcare system is continuing.

k) **Milestone 7.11:** A stand-alone meeting took place on 13 July to consider this item.

l) **Milestone 7.13(b)**: It was noted that clarity was still awaited from the HSE (through a separate mechanism) as to the uses to which the €3m to be spent on Patient Safety issues was being put.

AOB

4. Dr Mac Lellan expressed concern about the delay in identifying a Chair of the Maternity Guidelines Development Group, a key recommendation of the National Maternity Strategy.

5. The next meeting will take place in early September. In advance, DOH will prepare a report on the status of the Implementation Plan and the various milestones with a view to informing the Group as to the necessity of further meetings.

Actions Agreed:

i. DOH to revert to HSE with views on the report, "Key Risk Concerns in the Context of the HIQA Portloaise Report".
ii. Angela Fitzgerald to propose additional text on Recommendation 6 to ensure its full implementation.
iii. HSE to raise the need for full reporting of Maternity Patient Safety Statements with any hospitals failing to do so.
iv. DOH to revert to HSE with views on the Terms of Reference of the group set up to monitor the MPSS process.
v. DOH to revert to HSE with views on the template for the Hospital Patient Safety Statement.
vi. HSE to establish a governance group for the Hospital Patient Safety Statement process.
vii. HSE to finalise the business case for the patient safety culture survey.
viii. DOH to prepare a report on the overall status of the Portlaoise Implementation Plan.

David Keating
Patient Safety Unit
14 July 2016