Oversight Group for the Implementation of Recommendations in the HIQA Investigation Report on Portlaoise Hospital
12th Meeting – Thursday 30th June, 2016

Report of Meeting

Present

Tracey Conroy (Chair)	Assistant Secretary, Acute Hospitals Division
Dr Kathleen Mac Lellan	Director of Patient Safety and Clinical Effectiveness
Joan Regan	Acute Hospitals Division
Sheila O'Connor	Patient Focus

Apologies

Dr Tony Holohan	Chief Medical Officer
Dr Siobhan O'Halloran	Chief Nursing Officer

In Attendance

Liam Woods	Acute Hospitals Division, HSE
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 26th May 2016 were agreed.

2. The 8th Report from the Oversight Group covering the period to 30th April, 2016 was submitted to the Minister on 2nd June. This report was circulated to the Group.

3. The Oversight Group reviewed the Implementation Plan Report No 10, covering the period to 31st May 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 2:** A/Sec Tracey Conroy informed of progress in relation to appointments to the boards of Hospital Groups.

   c) **Recommendation 5**: Eileen Ruddin noted that the final interviews for Director of Midwifery posts were taking place.

   d) **Recommendations 6[1] and 7d**: It was agreed that a new set of actions will need to be developed in order to ensure these elements have been fully

[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.

implemented. The HSE will forward draft text for consideration by the Group. This should outline the phases and inputs necessary to deliver the required outcomes e.g. risk report, Hospital Group strategy, hospital model etc.

e) **Milestones 6.13 and 6.14**: HSE undertook to forward a note on the development of obstetric networks. HSE are also to forward proposals for a more detailed approach to these milestones to ensure implementation by all Hospital Groups for consideration by the Group.

f) **Milestone 6.16**: An interim Programme Lead has been selected. Mr Killian McGrane will take up duty in late August.

g) **Milestone 6.21:** A group has been set up to oversee compliance with the provision of mandatory training in relation to the 10 priorities identified under Milestone 6.19. It will have its initial meeting on 4 July next.

h) **Milestones 6.22-6.23**: Dr. Mac Lellan recalled the need for all maternity hospitals to publish full Maternity Patient Safety Statements each month. HSE informed that a group was being convened to monitor the process and detect emerging trends, and will also have ownership over the metrics. HSE undertook to forward the Terms of Reference of the group.

i) **Milestone 6.27**: HSE have convened a meeting for the week of 4 July to identify metrics for inclusion in the Hospital Patient Safety Statement.

j) **Milestone 6.29**: Approximately 260 people have been identified as working in the area of clinical audit and related fields; HSE are examining how to ensure their work is aligned with overall priorities rather than seeking new resources. The role and interactions with NOCA was raised for consideration in this regard.

k) **Milestone 6.42**: A meeting with Angela Fitzgerald, Eileen Rudin and Dr Kathleen Mac Lellan was to follow directly after this meeting to discuss the draft HSE business case for the patient safety culture survey.

l) **Milestone 6.51 and 6.52:** HSE are considering how best to investigate patient safety incidents, including whether the default response of a full systems review remains appropriate. Significant numbers of staff trained in investigative procedures have been identified.

m) **Milestone 6.57**: HSE will forward an update to the Group.

n) **Milestone 7.9:** Dublin Midlands Hospital Group continuing to follow up on this point; HSE noted that timelines may need to be adjusted.

o) **Milestone 7.11:** A stand-alone meeting has been scheduled for 13 July to consider this item.

p) **Milestone 7.13(b)**: Discussions are on-going in relation to building patient safety capacity at hospital and Hospital Group level.

4. The next meeting will take place on the 14th of July. A determination on the need for further meetings of the Group will be made then.

Actions Agreed:

i. HSE to forward draft text for consideration by the Group in order to ensure full implementation of Recommendations 6 and 7d.
ii. HSE to forward a note on the development of obstetric networks in relation to Milestones 6.13 and 6.14. HSE are also to forward proposals for a more detailed approach to these milestones to ensure implementation by all Hospital Groups for consideration by the Group.
iii. HSE to forward the Terms of Reference and the membership of the group that has been set up to support the implementation of Maternity Patient Safety Statements.
iv. HSE to forward an update to the Group in relation to Milestone 6.57.
v. Killian McGrane to be invited to the next meeting of the Group on 14th of July.
vi. Standalone meeting on Patient Safety Culture Survey to follow.

David Keating
Patient Safety Unit
4 July 2016