Oversight Group for the Implementation of Recommendations in the HIQA Investigation Report on Portlaoise Hospital
11th Meeting – Thursday 26th May, 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
Dr Siobhan O'Halloran	Chief Nursing Officer

Apologies

Tracey Conroy	Assistant Secretary, Acute Hospitals Division
Dr Susan O'Reilly	CEO, Dublin and Midlands Hospital Group

In Attendance

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

Admin Support

Paula Monks	Clinical Effectiveness Unit
David Keating	Patient Safety Unit

1. The minutes of the meeting on 7th April 2016 were agreed.

2. The 7th Report from the Oversight Group covering the period to 29th February, 2016 was submitted to the Minister on 12th April. This report was circulated to the Group.

3. The Oversight Group reviewed the Implementation Plan Report No 8, covering the period to 31st March, and also Implementation Plan Report No 9, which covered the period to 30th April 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) There was discussion of whether Recommendations 6[1] and 7d have been fully addressed. The HSE undertook to reflect on this point and revert to the Group.

b) The HSE report arising from the requirement that each Hospital Group undertake a Risk Assessment of clinical and corporate governance is being finalised (Recommendation 6.5).

[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.

c) The HSE provided an update on the progress Hospital Groups are making in developing clinical governance models in line with the National Maternity Strategy (Recommendation 6.13).

d) The HSE will forward further detail in relation to the mandatory training requirement contained in Recommendation 6.21.

e) In relation to Recommendation 6.23, the HSE undertook to forward to the Chairman the Terms of Reference and the membership of the group that has been set up to support the implementation of Maternity Patient Safety Statements.

f) In relation to Recommendation 6.27, the Chair stressed the importance of early commencement of the publication of the Hospital Patient Safety Statements. The HSE will forward Hospital Patient Safety Statements to the DOH.

g) On Recommendation 6.29, the HSE are currently assessing the resources required to undertake audits and will revert with the outcome at the next meeting.

h) On Recommendation 6.38, the CNO advised on the importance of liaising with National HR Director Rosarii Mannion.

i) The group considered the business case for the patient safety culture survey (Recommendation 6.42). It was agreed that a standalone meeting on this topic would be useful.

j) On Recommendation 7.8, the HSE informed that an interim solution creating a dedicated space for paediatric triage was being put in place in Portlaoise Hospital.

k) The end date for Recommendation 7.13(b) was changed to 31 December 2016. Liam Woods is to follow up with Patrick Lynch in relation to funding of an in-service plan and actions required.

4. The new Milestones proposed for the February report in relation to (a) follow up with families to assure that they have been provided with any additional supports required and (b) a Family Report were recalled. It was agreed that engagement with the Dublin Midlands Hospital Group on these points would continue. A smaller meeting may be required.

5. It was noted that HIQA had commenced a follow-up review of Portlaoise Hospital to provide external assurance in relation to implementation of the Recommendations.

6. The next meeting will take place on the 30th of June. It was provisionally agreed that a further meeting would be held on the 14th of July.

Actions Agreed:

i. HSE to reflect on whether Recommendations 6 and 7d have been fully implemented and revert to the Group.
ii. HSE to forward further detail in relation to the mandatory training requirement contained in Recommendation 6.21
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 Hospital Patient Safety Statements to the DOH.
v. HSE to revert to Group with an assessment of resources required to undertake audits. (Recommendation 6.29)
vi. Standalone meeting on Patient Safety Culture Survey to be arranged (8 June suggested, TBC).
vii. Liam Woods to follow up with Patrick Lynch in relation to defined funding in the 2016 HSE Service Plan for patient safety including dedicated posts and actions required in relation to Recommendation 7.13(b)
viii. DOH to follow up on the possibility of arranging a small follow-up meeting with Dublin Midlands Hospital Group in relation to no. 4 above.

David Keating
Patient Safety Unit
2 June 2016