Note for the Minister's Information

Fifth Report from the Oversight Group for the Implementation of Recommendations in the HIQA Investigation Report on Portlaoise Hospital

1. This is the fifth report from the Oversight Group to the Minister on the progress being achieved in the implementation of the HIQA recommendations. The report covers progress made for the period to 31st December, 2015 which was discussed at the Oversight Group meeting on 26th January 2016. The Implementation Plan shows a large number of actions completed and a large proportion on track for implementation by the timeline set.

    (a) There are minor challenges in relation to some actions. These challenges are largely due to timing issues where the action is being progressed but it has missed the project completion date.

    (b) With regard to the Maternity Patient Safety Statement the Department has received a letter from the HSE today informing us of the HSE's intention to commence publication of the Maternity Patient Safety Statements for the 19 maternity units by the end of this month.

2. On 15th January, 2016 a meeting took place with Dr Susan O'Reilly following the Minister's visit to Portlaoise on 12th January. Five specific actions were agreed for the HSE at that meeting and the Minister's email of 21st January, 2016 also posed four questions in relation to concerns around Portlaoise implementation (***Appendix A***).

3. Dr Susan O'Reilly has responded in a letter dated 2nd February, 2016 to the concerns expressed and the actions required of the HSE.

4. It is intended to add two new items to the Oversight Group deliverables for monthly reporting which address the key areas referred to in 2 above. An update on progress for each is provided as follows.

    (a) Case Reviews and Support for Families

    Initial discussions have occurred between Dr O'Reilly and Patient Focus. A meeting will be held with Dr O'Reilly, Patient Focus and Dr Peter McKenna on 5th February. Department Officials will be in attendance. A further update will be provided to the Minister on family support and family concerns regarding case reports after this meeting.

    Specialised bereavement support and therapy may be of added value in addition to the general availability of counselling services. Dr O'Reilly has discussed this with Liam Woods, HSE, and with Dr Sharon Sheehan, the Master of the Coombe Women & Infants University Hospital Women & Infants University Hospital. Both Dr Sheehan and Dr O'Reilly firmly believe that if they recruited a nurse/midwife/mental health nurse or counsellor to work as part of a team, it would be a model of care which would enhance the level of support now available. This individual would need to be embedded in a Coombe Women & Infants University Hospital/Portlaoise network. Currently, the Coombe Women & Infants University Hospital has a part time neonatal psychiatrist whose time is already fully committed. The HSE are proceeding with

recruitment of additional consultant level staffing, but in light of the challenges in filling psychiatry posts, they will also endeavour to find sessional support. All of this work is in train.

(b) Building Patient Safety Capacity

The HSE Service Plan for 2016 provides funding to support patient safety. This is to develop capacity for development of quality and patient safety across all services whereby each service has a defined patient safety and quality operating model to address service user advocacy, complaints, incident management and response, learning systems, service improvement, clinical audit and change. The HSE Quality Assurance and Verification Division will support this work with the Acute Hospital Division.

(c) Accountability

The Department is concerned at the length of time it is taking to complete the HSE's disciplinary investigation process following the publication of the HIQA Portlaoise Report.

The HSE have been asked to give consideration to the evidential base and seek legal advice regarding any further action it could take in relation to cases reviewed where the doctor is no longer practising or is not on the Medical Register. Dr O'Reilly has outlined that in relation to physicians who are no longer on the medical register, if issues arise re their clinical performance which in the view of the independent reviewers and Dr O'Reilly as Commissioner give rise to serious concerns, she will escalate this to Liam Woods, and where necessary, request advice from the HSE legal services.

Dr O'Reilly has begun an engagement with Ms Eunice O'Raw, barrister for the HSE, re the State Claims Agency and the Statute of Limitations.

5. The establishment of a National Advocacy Service is a project stream of work for the National Patient Safety Office (NPSO) to be established within the Department. In advance of a commencement date for the Office and recruitment of staff the Department has commissioned the Health Research Board to undertake a review of international advocacy models to inform the policy framework for a national advocacy model. Identifying and agreeing a suitable model for Ireland, undertaking a consultation process with key stakeholders, scoping out the resource and operational requirements for the new service and bringing the new service into being is required. It is intended to examine potential support for current advocacy services in advance of establishment of new advocacy service through an expansion of the capacity of existing services.

6. A copy of the Oversight Group's Implementation Plan to 31st December, 2015 will be placed on the Department's website in the coming days.

Dr Tony Holohan,
Chief Medical Officer and Chairperson of the Oversight Group
5th February, 2016

Appendix A

Five Actions Agreed for the HSE at the meeting on 15th January, 2016

The HSE:

1. will seek advice from Patient Focus with regard to further support that can be provided to the families,

2. will consider the identification of a nurse/midwife liaison midwife with relevant bereavement or other skills to offer additional support to families for a period up to 2 years,

3. will give consideration to the evidential base and seek legal advice regarding any further action it could take in relation to cases reviewed where the Doctor is no longer practising or is not on the Medical Register,

4. will have a discussion with the State Claims Agency regarding cases where the Statute of Limitations has expired,

5. give consideration to scaling up of patient safety capacity taking into account that there is defined money allocated in the HSE 2016 Service Plan

Questions posed by the Minister in his email of 21st January, 2016

1. The Update states that the project to establish a patient advocacy service is delayed. How long a delay do we think we might be facing? This is a key recommendation of the HIQA Report.

2. The report references the meeting with the families in Portlaoise on the 12th January and states that the Oversight Group intends to press the HSE further to ensure arrangements and resources are in place to meet needs identified by families. I would like to receive an update, when a response is received from the HSE. Specifically it was clear from the meeting that some families had concerns about their interactions with HSE regarding case reviews. What follow up is due to take place?

3. Concern about a perceived lack of accountability for events in Portlaoise was a feature of many of the parents contributions and again features this morning in coverage of the publication of the systems analysis review into the death of Baby XX. Are there any actions which could be undertaken to address these concerns?

4. Last week the HSE indicated that it would seek to give some greater clarity as to the timescale for the completion of the investigation it initiated following the HIQA Portlaoise Report. Can an update be got from the HSE in respect of this matter.