Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Safety and Quality Committee Meeting

Minutes

A meeting of the HSE Safety and Quality Committee was held on Wednesday, 19 February 2020 at 10.00pm in Indigo Room, Dr Steevens Hospital, Dublin 8

Members Present: Prof Deirdre Madden, Prof Fergus O'Kelly, Ms Anne Carrigy, Dr Cathal O'Keeffe, Dr Chris Luke.

HSE Executive Attendance: Dr Philip Crowley, Mr Dara Purcell, Ms. Niamh Drew, Ms. Joanne Lee

Apologies: Ms Yvonne Traynor, Ms Margaret Murphy, Dr Colm Henry, Mr Patrick Lynch

Joined the Meeting: Prof Risteard O Laoide (item 3), Mr Damien McCallion (Item 3), Mr Philip Lee (Item 3), Ms Cornelia Stuart (Item 4), Mr Phelim Quinn (Item 5), Ms Mary Dunnion (Item 5), Mr Kilian McGrane (Items 6/7), Dr Peter McKenna (Items 6/7), Ms Angela Dunne (Items 6/7), Ms Fiona Bonas (Item 8), Ms Suzanne Maloney (Item 9), Ms Angela Tysnall (Item 10)

1. Introduction and Chairperson's Remarks

D Madden took the Chair and welcomed members to the meeting of the Committee.

- Minutes of the Meeting on 22nd January 2020 Approved
- Status update of Committee Action Log – Discussed and Noted

The Chair updated the Committee on matters that had been brought to the Board's attention from the last meeting.

The Chair discussed the paper in relation to the Safety and Quality Committee's Annual Report. The Committee reviewed this paper and suggested that information relating to the previous Risk Committee should be added as an appendix.

No conflict of interest was declared.

2. Executive Members joined meeting

The Chair welcome the Executive to the Committee meeting.

3. Interval Cancer Audit Report

Prof Risteard O Laoide, Mr Damien McCallion, and Mr Philip Lee joined the meeting to discuss the recommendations of the Expert Reference Group in relation to Interval Cancer Audit. A draft accompanying letter from the Board to the Minister, and a proposed action plan in relation to implementation of the recommendations of the report were approved. The Chair will report on this item at the next Board meeting.

4. Patient experience

Ms. Cornelia Stuart presented the Committee with a video on a patient experience in relation to a miscarriage misdiagnosis and the subsequent response of the hospital.

The Committee thanked Cornelia for the video and acknowledged that the information provided was useful, contextualised and was what the Committee would like to see more of going forward. The Committee felt the message from the video as portrayed by the patient was around the learning that came from this incident.

C Stuart informed the Committee a review of the Incident Management Framework (IMF) will be republished in Quarter 2 and will look at how to support staff and service users in the aftermath of an incident.

The Chair suggested that a session be dedicated to Incident Management Framework at a later date.

5. HIQA

The Chair welcomed Mr Phelim Quinn (CEO of HIQA) and Ms Mary Dunnion (Chief Inspector of Social Services and Director of Regulation, HIQA) and thanked them for agreeing to attend the meeting.

P Quinn gave an overview of the National Care Experience Programme (NCEP) which was established in 2019 to encourage people to share their experience of care and to use this information to improve the quality and safety of services. He advised that the National Inpatient Experience Survey was very successful in terms of the response rate and that there had been statistically significant improvements for thirty survey questions, including in relation to hospital discharges. He also advised of the areas which had not improved such as waiting times for admissions and help in getting to the bathroom.

He also discussed the National Maternity Experience Survey which is a national survey providing women in Ireland with the opportunity to share their experiences about maternity care. He informed the Committee that the survey is currently live and 4,890 women that gave birth in October have been invited to participate. Over 1,000 women have responded to date.

The Committee agreed that consideration should be given in relation to aligning the HSE Staff survey and Inpatient Experience survey. P Crowley to consider these pieces of work and examine how they track each other.

M Dunnion discussed with the Committee monitoring in Healthcare and Maternity Services. She spoke about the standards and the responsibly of the organisation to adhere to these standards. Each Hospital assessed themselves against the standards through review onsite inspections. She highlighted that 19 reports were recently published in respect of the maternity hospitals and units and 1 overall report. She advised the summary findings were overall very positive. The areas that raised concern were around infrastructure of maternity units and hospitals. She discussed the recommendations of the report and advised that most of them had been implemented. She advised that the HSE will now be expected to publish its implementation plan.

The Chair thanked both M Dunnion and P Quinn for their attendance and invited M Dunnion back at a later date to discuss Regulation of Disability Designated Centres.

6. Topic for discussion

The Chair welcomed Mr Kilian McGrane, Dr Peter McKenna, Ms Angela Dunne to the meeting.

Dr McKenna gave an overview of Neonatal Encephalopathy (NE) to the Committee. Neonatal Encephalopathy is a clinical condition in the term infant defined by abnormal neurological behaviour with the onset occurring at or shortly after birth. NE is manifested by an abnormal level of consciousness with or without the presence of seizures and is often accompanied by difficulty imitating and maintaining respirations, depressed tone and depressed reflexes, poor suck and swallow.

Dr McKenna discussed Therapeutic Hypothermia (TH) which is considered to be the standard of care for infants with moderate to severe NE who meet inclusion criteria. He briefed the Committee on the Neonatal Therapeutic Hypothermia Report which he noted as a game changer as the reports are a register of data and intelligence around TH giving key markers for mothers who are at higher risk of having an NE event. He highlighted the impact that NE has on a family and the lifelong consequences for the babies involved. He also spoke about the financial burden on the state and the HSE.

The National NE Action Group have drafted a number of recommendations and are seeking support from the Committee to bring to the Board for endorsement. Dr McKenna advised that the amount of funding sought was relatively small but would have huge benefits.

It was agreed that CCO would bring recommendations to the Committee and that the Chair would discuss at Board level.

7. National Maternity Strategy

K McGrane gave an overview of the National Women's and Infants Health Programme (NWIHP) which was established in 2017, following a Government decision in the aftermath of the Portlaoise report. He discussed the National Maternity Strategy (NMS) which has 3 clear pathways set out for women in 16 of the 19 units. He briefly discussed the recent HIQA report into maternity services and advised that he is working with HIQA on the National Maternity Survey.

He highlighted the issue around funding for the implementation plan for the NMS. The funding received to date has not allowed as much progress as envisaged in the area of hiring additional midwives to implement the supported care pathway.

The Committee agreed that funding was a priority for this issue and the Chair agreed that she will report on this to the Board.

C O'Keeffe left the meeting at the conclusion of this item.

8. Quarterly Reports

The Chair welcomed Ms Fiona Bonas to the meeting. Ms Bonas gave an overview of the National Cancer Control Programme which was set up to implement the National Cancer Strategy and discussed the centralisation of Cancer Surgery.

She highlighted that considerable progress had been made towards the centralisation of cancer surgery. The centralisation of Breast surgery was the first priority of the NCCP which was completed in 2009. Following this the reorganisation of oesophageal, pancreatic, lung and prostate surgery was prioritised. Despite the considerable progress that has been achieved in surgical centralisation between 2007 and 2018, the outstanding work that remains is challenged by lack of funding.

The Committee agreed to endorse the strategy and for the Chair to bring it to the Board for discussion. The Chair requested that it be built into the Safety and Quality workplan twice yearly.

The Committee discussed inviting the Chief Financial Officer to a Safety and Quality Committee meeting to discuss funding strategies and the development of the dashboard to show the running cost of strategies in the HSE.

9. Topic for Discussion

The Chair welcomed Ms Suzanne Maloney to the meeting to give an overview of the National Complaints Casebook.

S Maloney discussed the importance of listening to patients and service users to make sure we don't lose what we stand for as an organisation and also through looking at complaints and trends we can improve the culture of the HSE. She highlighted that complaints are a valuable resource of information about our services which can help identify recurring and underlying problems as well as the areas for improvement.

An outline of the complaints management process was discussed and the procedures that are followed to ensure that cases identify learnings from the complaints investigations and reviews so that initiatives to address and rectify issues can be replicated in other areas. She highlighted that Complaint Mangers have been appointed within CHO's, Hospital Groups and National Services and have responsibility for ensuring that complaints received are examined and acted upon and discussed with service managers.

The Committee reviewed the casebooks provided prior to the meeting and agreed that a further box needed to be added to prove learnings from complaints. It was also agreed that complaints issues from staff should be dealt with in the same manner.

The Committee thanked Ms Maloney for her presentation and invited her back at a later date to discuss identifying trends and improvement plans.

10. Open Disclosure

The Chair welcomed Angela Tysall to the meeting to discuss Open Disclosure.

A Tysnall gave an update to the Committee on the Open Disclosure Policy which was launched in November 2019 and the work that has been done to implement the policy across all health and social care services. Approx.45,000 members of staff have received briefings/ training on open disclosure to date and approx. 500 people have been trained as trainers. She advised that each area has an Open Disclosure Lead and that trainers are available in every Hospital Group, Community Healthcare Organisation and Voluntary Organisation. She informed the Committee that work with the ICGP is in progress for training to be rolled out to GP's and Open Disclosure is also included in Nursing and Midwifery programmes.

A Tysnall also discussed mandatory open disclosure which is pending in the Patient Safety Bill and the implications for the HSE in relation to the implementation of this legislation. She highlighted some challenging issues in the Bill such as the requirement to complete detailed forms when a notifiable incident occurs. This led to a detailed discussion with the Committee and P. Crowley in relation to the proposed Patient Safety (Notifiable Incidents) Bill during which the Committee expressed serious concern about the significant potential distress and anxiety for patients and staff if the current legislative proposals are enacted. The Chair undertook to raise this issue with the Board.

The Chair thanked Ms Tysnall for her work on this important issue to date and the Committee suggested a look at communication skills training in general and how this is managed in the organisation as an agenda item for a later date.

8. Report from CCO

Dr Crowley provided an update on the current and strategic safety and quality issues from across the functions of the CCO.

He informed the Committee that he attended an all-island Quality Improvement Conference this week and how it was a very positive day attended by many staff from within the HSE and from Northern Ireland. The Chair also attended this conference and felt it was powerful, uplifting and demonstrated the strong commitment to quality improvement amongst staff. She congratulated Dr Crowley and his team on the successful event.

Dr Crowley provided a brief update on the Coronavirus and Influenza to the Committee.

He then discussed with the Committee a summary document received by Prof Frank Murray in relation to the workshop that was held several weeks ago on Controls and Assurances on the Employment of Consultants not on the Specialist Division of the Medical Register. The Committee agreed that the document would not provide the necessary assurance sought by the Board. It was agreed that more workshopping of concrete proposals needs to be done before bringing this matter back to the Board.

12. Any Other Business

Date of Next Meeting: 11th March 2020 at 10.30pm, Indigo Room, Dr Steevens Hospital.

The meeting concluded at 16:15pm

Signed: Deirdre Madden

Deirdre Madden
Chairperson

24/11/20

Date