HSE Safety and Quality Committee Meeting

Minutes

A meeting of the HSE Safety and Quality Committee was held on Tuesday 8th March 2022 at 9.00am via teleconference

Committee Members Present: Prof Deirdre Madden (Chair), Prof Fergus O'Kelly, Ms Anne Carrigy, Ms Jacqui Browne, Dr Cathal O'Keeffe, Dr Chris Luke, Ms Margaret Murphy (Joined at 12:30pm)

HSE Executive Attendance: Dr Colm Henry (CCO), Dr Orla Healy (ND Q&PS), Dr Geraldine Smith (ND IA), Mr Liam Woods (ND Acute Operations) Mr Mark Brennock (ND Communications), Ms Niamh Drew, Mr Pat Galvin.

Joined the Meeting: Ms Sharon Hayden (Item 7), Dr Siobhan Ni Bhriain (Item 3), Mr Michael Walsh (Item 5), Mr David Hanlon (Item 5), Mr Mac MacLachlan (Item 5)

Apologies: Ms Yvonne Traynor

1. Governance and Administration

Following a short private meeting of the Committee, D Madden took the Chair at 9.30am and welcomed members of the Committee and the Executive to the meeting.

No conflicts of interest were declared and the Minutes from 15th February 2022 were approved subject to minor wording change.

2. Quality Profile Summary

The Committee were given a high-level overview of the Quality Profile Summary. The main indicators were brought to the Committee's attention with most trends remaining problematic. The Committee were advised of a new indicator now added related to CAMHS referrals. The Committee were unclear of the measurement of urgency in CAMHS. It was explained that further clarity will be provided on this once the Audit has been completed but recent investigation seems to show that the focus is on acute cases. The Committee commented on the lack of information on Ambulance turnaround to which they were advised that no new data was available but written detail is to be supplied later this month. The Committee questioned getting more up to date data as some data is historic and they

were advised that due to the process involved in gathering, collating, confirming and charting the data this is the most recent data and the indicator is showing the most recent data available and noted that trends will not change in the space of a month. A brief discussion took place about the indicators, with the possibility of new indicators to be added, with a meeting to be held in May to discuss the indicators.

3. National Integrated Care Programme – Older Persons

Dr Siobhan Ni Bhriain joined the meeting

The Committee welcomed a high-level presentation from Dr Ni Bhriain on National Older Persons programme which outlines the progress to date on NICPOP. The Committee were advised of the Chronic Disease Service Model, which provides a mixed input of services within the team with the aim to have people living well at home. There is also a lot of work being carried out in the Community setting. Frailty, falls and Dementia are key focus areas, with early support and discharge being important aspects. The Committee were given some examples of services provided with Age friendly initiatives, frailty screening, integrated care teams, Ambulatory care hub and Acute frailty units being examples of the pathways available. The Committee were brought through an example of Governance programme, shown how implementation works in a local area and advised how integrated care works between CHN's and community specialist teams. Dr Ni Bhriain gave further detail relating to the Ambulatory Care hub before finishing the presentation by showing some of the resources available. The Committee thanked Dr Ni Bhriain for her presentation and advised that it was very helpful for their understanding of this area.

Dr Siobhan Ni Bhriain left the meeting

4. National Review Update

NCD NQPS provided the Committee with an update on the implementation of the Maskey report and an update on NIRP Terms of Reference.

NCD NQPS advised the Committee that the HSE has established an oversight group for the implementation of the Maskey Report, which will be guided by agreed Terms of Reference and will be jointly chaired by the Chief Operations Officer and Chief Clinical Officer. The NCD also updated the SQC on audit recommendations in the Maskey report. Discussion is on-going on the audit of prescribing practice in CAMHS. The HSE Clinical advice and stated preference is to focus the prescribing audit on ADHD, in the first instance as this is what was the area of concern identified un the Maskey report published in January 2022. It is also the area for which a standard exists against which an audit could be conducted. That audit could be expanded should the ADHD audit raise

concerns in a particular area. An evidence based national clinical audit of psychotropic prescribing in CAMHS is also being developed but this is a longer-term project as it involves standard development. Notwithstanding the clinical advice and at the request of the Minister, options for an immediate wider audit of prescribing were being explored. The Minister has requested the immediate extended audit to provide assurance in regard to prescribing practice in CAMHS nationally. The Committee commented on the staffing and resources that would be required to carry out this audit, which could perhaps be used elsewhere to better effect. NCD NQPS advised the Committee that it would be possible to conduct the wider review albeit with a less rigorous methodology. After some discussion the Committee felt that this should be considered by the HSE Board, as it is a huge undertaking and a potential misuse of valuable resources. The Committee felt that this is a political reaction to a currently topical issue and that clinical audits should not be subject to political influence.

ND NQPS advised the Committee that the Terms of Reference for NIRP have been submitted to the working group. The Committee questioned the timeframe for this to be carried out and they were informed it would be May at the latest for a conclusion. After questioning the amount of patient representatives with NIRP the Committee were informed that more patient reps will be invited. a The Committee discussed the fact that NIRP is a voluntary process and people may be reluctant to join if they are going through either a HR process or a Garda investigation. It was noted that referrals to other organisations may be required.

5. National Clinical Programme for people with Disability

Mac MacLachlan, Michael Walsh and David Hanlon joined the meeting.

The Committee were given an overview presentation of the National Clinical Programme for people with Disability by Prof MacLachlan, National Clinical Lead with NCPPD. He advised the Committee that the National Clinical Programme for People with Disability (NCPPD) seeks to support the provision of equitable, effective and efficient assessments, interventions, and supports for people with disability; that are evidence-informed and context-appropriate, and provided within a social and rights-based model of disability. The 2016 census indicated that there were 643,131 people, or 13.5% of the population, who reported that they had a disability. Approximately 10% of this number use specialist disability services; such as Residential Services, Respite, Personal Assistants, Day Services, Home Care Services and interdisciplinary services and supports (with an approximate budget of €2.2 Billion).

The NCPPD was established in March 2020 amidst a global pandemic and a substantial programme of work had already been developed over many years through collaborative working between the National Disability Operations function and the National Disability Strategy and Planning function, aligned to government policy. The Committee were advised of the clinical team setup, the three sub

committees and the Children's Disability Network Teams. The Committee were also brought through an overview of the teams and supports that are part of the Integrated Services and Supports for Children with Disabilities. The Committee were also briefed on the supports/enablers, living locations and the health services available under the various plans, programmes and strategies, with the National Service Plan, the Disability Action Plan and the Neuro Rehabilitation Strategy being amongst these. Prof MacLachlan brought the Committee through a high-level view of the Programme Activities which include service and support pathways with some important pieces being highlighted – Progress of implementation of Neuro Rehabilitation Policy, Engagement with Mental Health programme, Digital and Assistive Technology Task Group and Assisted Decision-Making Capacity Act. The Committee briefly discussed the challenges and opportunities pointed out, which included recruitment & retention of staff. The Committee were advised that training needs to be interdisciplinary so that people can work in the community setting right from the start and a meeting has been requested by the programme with the Minister to discuss training needs. Prof MacLachlan also informed the committee of a new collaboration between the NCPPD and the WHO Europe Office on developing recommendations for rights-based leadership and governance in health and social services across Europe. Prof MacLachlan concluded by noting that in his view clinical risks are associated with disciplinary dominance and hierarchical decision making in clinical teams; and he advocated for open (to all professions) competitions for clinical leader positions in the HSE, which should be based on competency. The Committee expressed their thanks for an inspiring presentation as well as commending the team for the progress made within a short space of time.

Mac MacLachlan, Michael Walsh and David Hanlon left the meeting.

6. Internal Audit

ND IA, ND Communications & ND Acute Ops joined the meeting

ND IA gave a high-level overview of the findings of the report on Compliance with Postmortem practices and procedures. ND IA advised that Acute Operations requested this audit and the audit commenced on 11th November 2021. The review focused on post-mortem practices completed between 1 January 2018 and 31 October 2021 in the hospital mortuaries of all 25 hospitals where postmortems are carried out. The audit has now been completed and the final report issued on 18th February. The audit reviewed compliance in this area on; the information provided to families, securing relevant consent from families and the ultimate disposal of retained organs. Due to the significance of the findings, the overall audit opinion is 'Unsatisfactory'. The audit made 8 recommendations (6 High and 2 Medium rated) which have been accepted by the National Director of Acute Operations and the Chief Clinical Officer. The audit found that the HSE Standards and Recommended Practices for Postmortem Examination Services 2012 ("The Policy") has not been

reviewed since implementation in 2012, leading to impracticalities with the administrative processes specified for mortuary staff. It does not specify guidelines/timelines to be followed where issues arise with the ultimate disposal of a retained organ. This has led to longer retention periods than desired resulting in organs being retained for over 1 year. Consent policies were not in place in some locations. There are disparities and inconsistencies in practices, communication and responsibilities between different districts. For example, a number of coroners only give verbal authorisation for postmortems while others give written consent. The Committee questioned the reasoning for only going back to 2018 and why not further back. ND IA advised that due to the strict timelines to undertake the audit and present the report, the decision was made to go back to 2018, a period of almost 4 years, spanning the operation of practices before and during Covid, in order to give a good representation. The Committee also asked about the follow up of recommendations from the report, to which ND IA advised that there will be a follow up audit in due course but will have to allow time for the implementation of the recommendations.

ND Acute Ops gave a brief overview explaining the measures being actioned to ensure these events do not happen again. He advised the Committee that staffing measures have been actioned with approval for 6 perinatal pathologists agreed. A 2-year training process is required for these posts so the Committee questioned what measures will be in place in the interim period with ND Acute Ops advising that cross cover will be in place with Cork covering Limerick area, etc. ND Acute Ops advised that a plan is in place to address the 8 recommendations outlined within the report, with ND Acute Ops having oversight and will report to management on these actions with updates to be provided to the Committee. ND Acute Ops advised the Committee that further open disclosure discussions may need to be held with the families. The focus now is on being compliant currently with our standards and the hope is to standardise information with the Coroners Society and then implement countrywide. The Committee were happy that a plan is in place and look forward to future updates.

ND Comms informed the Committee on the communications approach, with the objectives being to ensure satisfactory appropriate open disclosure can take place with affected individuals before any media coverage and to ensure the public understand the issues that have arisen and the steps that are being taken to address them. The Committee were informed that the plan is to communicate after the disclosure meetings happen. ND Comms will be in continued contact with Acute Ops office to ensure appropriate timings. The proposal is to publish the Internal Audit report and issue a press briefing at the same time, with an appropriate spokesperson available for further explanations.

ND IA, ND Communications & ND Acute Ops left the meeting

7. CCO Report

CCO and Sharon Hayden joined the meeting

The CCO provided a high-level overview on several areas including the following;

The CCO started with a brief update on Covid figures and boosters. In the 7 days up to 2nd March there were 22,990 new cases reported (based on positive PCR results); down 21% on the previous week (28,979 new cases in the 7 days up to 23rd February). There have been 2,817,835 booster vaccines administered, 2,681,261 additional dose vaccines and 136,574 immunocompromised dose vaccines administered. Plans are being currently being reviewed in relation to the vaccination programme which will be completed in March.

Significant progress has been made by the COVID-19 Therapeutics Implementation Working Group to support the roll out of Covid-19 therapeutics recommended by the Covid-19 Therapeutics Advisory Group. Since the previous update to the Board, the Working Group has worked with Hospitals to coordinate stock control of the supplies of Covid-19 therapeutics and monitor the numbers of doses being administered weekly. Based on the advice of the Therapeutic Advisory Group and other information it was clear that the priority for patient safety was to deliver access to this agent as quickly as possible to those patients at greatest risk of severe disease.

At the last meeting the report from the National Screening Programme articulated a risk in relation to the ability to recruit consultant radiologists for BreastCheck. The CCO has requested NSS to establish a working group with representatives from the faculty, symptomatic services and breastcheck. The aim of this group is to explore short, medium and long term options, look at training positions, education, and the promotion of breast radiology as a career option. In the immediate term, BreastCheck continue to actively recruit and aim to appoint consultants into vacancies across all four units. They are also seeking additional capacity from both existing BreastCheck consultants and consultants working in symptomatic services within the bounds of the existing pay policy whilst recognising competing pressures across the health system and very competitive market. CCO to supply a report on staffing required for Screening for next meeting.

Significant progress has been made in implementing the recommendations of Dr Scally's Scoping Inquiry into the CervicalCheck screening programme. The latest quarterly progress report was published on the 3rd of March 2022 and shows that just four of 170 actions, arising from Dr Scally's

recommendations, remained to be completed at end 2021. The Minister for Health has requested Dr Gabriel Scally to conduct a final progress review of implementation of his recommendations, and this work is now underway

Cancer services are currently operating near full capacity, with some ongoing local difficulties related to staffing absences and acute capacity issues. Ongoing access to private services remains essential and this need is likely to continue for some time, particularly in clearing backlogs for non-complex cancer care and ensuring timely cancer treatment. Staffing, recruitment and retention in cancer services continue to be a challenge.

At the last Safety and Quality meeting it was agreed that the 6-month report on the OEST programme would be shared with the committee. OEST are moving to the next stage of the programme with involvement of all 19 maternity units from the 1st of April. At the last meeting a question was raised if the number of events which have been captured were expected. There were three maternal deaths, seven hypoxic-ischemic encephalopathy (HIE) and two Intrapartum deaths. Maternal death appears to be overrepresented, but they still remain a small number, and are potentially a statistical artefact, with an annual expectation of 5 – 7 for the whole country in a full year. As a result of these cases NWIHP issued a system notification to ensure that there was heightened awareness of these events. As the programme gains momentum within the system, it is anticipated that there will be increased engagement with the OEST and a rise in the number of cases reported. The OEST has designated four events that need particular attention, these are: a) Maternal death b) Intrapartum fetal death c) Early neonatal death d) Babies requiring therapeutic hypothermia B, c and d above apply to term babies with no life limiting conditions (as these conditions would have been known beforehand). These are the criteria outlined by the RCOG for Each Baby Counts since 2015.

Current HSE records indicate that there is a total of 747 nurses/midwives employed in CNS/CMS in the community (however a number of these post holders may be working as CNM2's). At the last safety and quality meeting last month there was a request to understand the breakdown of CNS/CMS specialist posts by geographical area this report will be shared at the next SQ meeting.

In November 2021, the Minister for Health asked that the number of ANMPs in the health service be increased from 2% to 3% of the workforce. The total nursing and midwifery workforce in the public system was 41,136 WTE (November 2021). At this time the total number of Advanced Nurse and Midwife Practitioners (ANMPs) was 733 WTE (1.75%) including 553 WTE Registered ANMP posts and 180 WTE candidate ANMP posts. These posts should have a renewed focus on the objectives of

Sláintecare and the HSE corporate objectives. There is an opportunity now to harness these advanced practice roles to support patients in the community and hospitals in managing integrated care. The DOH Letter of determination to the HSE set out a funding of 11.9milliom as part of the HSE National Service Plan 2022 new development initiative to expand the number of ANMPs in 2022 service. It is accepted that €1m will be required to support the education of candidate posts and there will be 164 WTE posts available. As a next step a paper is being developed to outline a governance structure to provide a strategic direction for these posts that will ensure that their future development aligns to with both the HSE and Sláintecare objectives.

The CCO provided the Committee with an update on Letterkenny University Hospital. The Price review was published by the SAOLTA Healthcare Group in August 2020. This review made 6 key recommendations and the SAOLTA group developed an action plan for their implementation. To date over 85% of the recommendations are complete and the remaining recommendations are being progressed. The CCO informed the Committee that he has requested the Clinical Director of NWIHP to meet with the Director of Women's and Children's Managed Clinical and Academic Network and arrange to meet clinicians in Letterkenny University Hospital in relation to the service and reported incidents. CCO has asked for an assessment and advice including any observations in relation to safety in the gynaecological department and any recommendations if necessary, to make it safer, bearing in mind any existing concerns emanating from reports in relation to the service.

The original guideline on PMB (2013, revised 2016) suggested that these women should be seen in a short timeframe. Interim guidance with specific timeframes was issued by the Acute Hospital Division August 2020. Now that we have specific timeframes the hospital groups are being asked to measure their performance against these specific timeframes. This is the first KPI in general gynaecology. A formal guideline has been commissioned which will be available later this year, it is anticipated that the principles in this guidance will be the same and the timeframe is unlikely to differ substantially. As part of the process of developing clinical guidance it is important that the most up to date evidence and research is reviewed. The guideline in addition to international evidence is reviewed under the clinical leadership of the NWIHP in the context of an Irish Health Care System and will be peer reviewed through the normal clinical governance structures set up by CCO. This process aims to ensure that clinical guidance development is transferable to clinical practice, aligned and integrated across the healthcare system, and there is clear clinical governance and oversight.

Although clinical genetics is an established medical sub-specialty and there are some pockets of excellence in the country, Ireland lags considerably behind other countries in harnessing the power of

genomic data and research to inform clinical decision making. There is now a large and increasing disparity between services offered in Ireland and international best practice. As a result, very few Irish patients are benefitting from advances in genomics and the gap is widening. Compared to other European countries, Medical Genetics in Ireland is under-resourced for both clinical and laboratory services. At present, the average waiting time for a routine genetics appointment is 2 years. Due to the lack of a genomic infrastructure, a significant volume of patient samples is sent overseas for testing leading to increased costs. In addition, tests that are carried out in-house have a higher unit cost compared to other 9 laboratories carrying out similar genetic testing. There is a shortage of trained genetic specialists, substantial knowledge gaps in the clinical workforce and a lack of genetic/genomic literacy across healthcare professionals and the public. Appropriate governance structures, policies, procedure, and protocols are not in place and Ireland has no strategy or funding in place to develop a genomic service to improve health outcomes, drive down the cost of care and fuel scientific innovation and discovery. There have been several reports published to date with recommendations for a national strategy and plan to develop and strengthen the genomics service. Following recommendations from this, the government committed to establishing a National Genetics and Genomic Medicine Network (NGGMN). The NGGMN aims to facilitate the development of a nationally coordinated service for genetics and genomics. Recruitment for a National Genetics and Genomics Medicine lead was first advertised in February 2020 and following a global, competitive, and open recruitment process a world leading expert in genomics was offered the position of Director of the NGGMN in January 2021, but the position was not taken up due to lack of multi annual budget for the service. The Committee were very disappointed to hear that the position is still vacant due to a lack of funding and felt a position should not be recruited if the funding is not available to run the service. A business case for genomic funding was submitted by the office of the CCO in September 2021. However, funding under the National Service Plan was not secured. The priority now is to support the progression of a Genetics and Genomics strategy with a single vision for the future of genetics and genomics. Genomics is now revolutionising how we deliver healthcare.

The Committee were given a brief update on Navan hospital, which is the last hospital to be brought back to a Model 2 hospital. CCO expressed concerns that this hospital cannot provide proper care and is a patient safety concern. Whilst the issue was brought to the attention of the Minister, there did not seem to be a sense of urgency about the actions needed. CCO advised that the next step is to write to the hospital and the Department, advising that the changes will be actioned, giving 4 weeks' notice of the change. The Committee were in agreeance that the Committee Chair would write to the Board Chair advising of the next steps needed and the urgency of this matter. The Committee were united

in their dissatisfaction with the situation and the delay in these important changes being made and strongly support the CCO's plan of action.

The Open Disclosure Annual Report has been reviewed and approved by the EMT for further presentation to the Safety and Quality Committee. The Annual Report provides an overview of the work of the office in relation to the office functions. The report provides an overview of the following; The Mission, Vision and Values of the National Open Disclosure Office, Key Developments in Open Disclosure during 2020, Managing the impact of the Coronavirus Pandemic and Covid-19 Restrictions on the work of the National Open Disclosure Office and Programme throughout 2020, An Update on the Operations Plan for the National Open Disclosure Office 2020, Update on the Implementation of the Recommendations from the report by Dr Gabriel Scally into CervicalCheck 2018, Update on the National Open Disclosure Training and Education Programme including a training report for 2020, Programme of work undertaken to improve the access to and uptake of open disclosure training by Medical Staff, Governance, Performance Measurement, Partnering with Patients and Service Users, Stakeholder Involvement, Sharing the Learning – case examples

8. National Clinical Programme for Ophthalmology

Item deferred to April meeting

9. AOB

The meeting concluded at 14.50

12th April 2022

Signed: _________________ _______________

Deirdre Madden

Chairperson **Date**