HSE Safety and Quality Committee Meeting

Minutes

A meeting of the HSE Safety and Quality Committee was held on Tuesday 13 December 2022 at 10.00am via MS Teams.

Committee Members Present: Prof Deirdre Madden (Chair), Ms. Anne Carrigy, Ms. Jacqui Browne, Dr. Anne Kilgallen, Ms. Mary Culliton, Prof. Fergus O'Kelly, Dr. Cathal O'Keeffe, Dr. Yvonne Traynor, Ms. Jacqui Browne

Apologies: Ms. Margaret Murphy

HSE Executive Attendance: Dr. Colm Henry (CCO), Dr. Orla Healy (ND QPS), Niamh Drew (Deputy Corporate Secretary)

Joined the meeting: Lorraine Schwanberg (Item 3 and 4), Angela Tysall (Item 3 and 4), Catherine Hogan (Item 3), Loretta Jenkins (Item 3), Sharon Hayden, General Manager to CCO (Item 5), Dr. Cora McCaughan (Item 6), Ms. Mary Day (Items 6 and 7), Grainne Cosgrove, Senior Statistician, QPS Intelligence (Item 7).

Minutes reflect the order in which items were considered and are numbered in accordance with the original agenda.

1 & 2. Governance and Administration

1.1 Welcome and Introductions

- The Chair welcomed the Committee members to the meeting.

- The Committee held a private session where the Chair provided a summary of the agenda, the relevant papers and approach to conducting the meeting, noting that the focus of the meeting would be to receive updates on key items and to suggest relevant actions as they became apparent.

2. Governance and Administration

- No conflicts of interest were declared.

2.1 Minutes

- The Committee approved the minutes of the 15th November 2022.

2.4 Matters for Noting

- The Chair informed the Committee that a briefing on the National Heart Programme had been included in their pack for noting. The Committee agreed that it would be beneficial to have this item added to the Committees work plan for discussion in May 2023, under the theme of Public Health,

- The Chair also updated the Committee on the Patient Safety Bill noting that there had been ongoing discussion with the Minister and advised that a further change to the Bill has been proposed by Government. The Committee are to be kept abreast of this.

- The Committee also agreed that a paper on 'Chronic Disease Management' should be presented in July.

2.5 Safety & Quality Committee Workplan 2023

- The Workplan for the period January to June 2023 was approved by the Committee. The Chair discussed the issues of duplication of items across other Board Committees and informed the Committee that a meeting with the other Committee Chairs has been scheduled to discuss further.

3. Patient Safety Together System

Lorraine Schwanberg, Assistant. National Director for Incident. Management, NQPS, Angela Tysall, HSE Lead for Open Disclosure, Catherine Hogan and Loretta Jenkins joined the meeting at 11am.

- The Committee was briefed on 'Patient Safety Together: sharing, learning and improving'. This a new open access HSE web-based platform that is designed to provide up to date QPS information for the purpose of sharing learning, supporting healthcare improvement and support collaboration to ensure that there is system wide learning from incidents and other patient safety sources. The system is a component of the patient safety programme to support the HSE Patient Safety Strategy 2019-2024.

- It was explained that the purpose of the system is three-fold: to support staff to use its content as a reliable resource for QPS learning to improve patient safety, to engage staff with incident reporting by closing the loop on reported incidents and supporting sharing of lessons learnt to help prevent similar incidents; to assist patients and service users to easily access information on QPS issues that are relevant to the Irish healthcare system and to keep them up to date with the latest information.

- Patient Safety Together will share learning by developing a multi-modal approach to sharing learning and by using up to date QPS information including incident management data, international evidence and feedback. This is in order to learn directly from Patients/Service users & Staff, learn from incidents, research & data and to signpost to QPS academic papers, resources, conferences etc. It was explained that the system will contain narrative patient safety stories that will give a voice to the patients/service users and staff who have been involved or impacted by patient safety related issues.

- The Committee questioned whether complaints would feed into the platform and was informed that .complaints will be shared through the Complaints Case book and other sources. NQPSD and complaints work collaboratively on a number of pieces of work although their reporting structure differs.

- On the issue of training – this is being delivered for the HSE NPSA Officers currently, including s38 organisations. The alerts will be available and accessible to all on the website but the oversight for s39s will be challenging.

- In response to a query about whether the team do targeted learning days that people can attend, the Committee was advised that a network was being established for QPS staff to collaborate and network, and that online learning and face-to-face learning events will be held.

4. Open Disclosure

- The Chair welcomed Angela Tysall to the meeting to present the Open Disclosure Annual Report 2021 which was presented in line with the Scally Recommendation Number 32 “An Annual Report on the operation of open disclosure must be presented in public session to the full Board that is to be appointed to govern the HSE” in his report “Scoping Inquiry into the Cervical Check Screening Programme” September 2018.

- A Tysall presented the report, noting the objective of the National Open Disclosure Programme is to promote and support a culture of openness and transparency through compassionate and empathic communication with patients, service users, their relevant persons and staff. She explained that the annual report sets out the areas of work, the successes and challenges experienced during the 2021 period.

- The Committee welcomed the report and discussed the key developments that had been achieved to date. Clarification was sought with regards to monitoring of compliance with Open Disclosure and the level of support given to staff to support them in the process. The Committee also discussed the importance of culture and noted the importance of the current work on culture in creating an open and transparent health service. It was agreed that the ultimate measure is the patient experience of Open Disclosure, and that training is key to improving this. The need for monitoring and assurance around some of the key steps of the Open Disclosure process (discussion, written notification and sharing of the review findings) for reported incidents was also discussed.

- **It was agreed that the National Open Disclosure Programme Training Report 2021 would be circulated to the Committee and the 2022 Report would be presented at the March 2023 meeting.**

5. Chief Clinical Officer

The Chief Clinical Officer joined the meeting at 12.15pm.

- The CCO provided an update on winter viruses. This included an update on the autumn vaccination programme for Flu and Covid 19. An update was given on the uptake of the antiviral paxlovid. An overview and update was given on Invasive Group A Streptococcus (IGAS) to date in 2022, inclusive of three deaths from iGAS. Group A Streptococcus is not notifiable in Ireland, unlike the UK, where iGAS is notifiable. The CCO noted that the HSE Covid-19 Vaccination Programme was awarded the Project Management Institute Public Sector Project of the Year and the Greatest National Impact Project of the Year for 2022 on 24th November.

- The CCO provided an update in relation to the Patient Safety Bill, outlining that there have been ongoing discussion with the Minister, with further changes to the Bill being proposed by Government. **The CCO agreed to keep the Committee updated on this**.

- The CCO advised that Dr. Gabriel Scally's final progress review of the implementation of the recommendations of the Scoping inquiry into the CervicalCheck screening programme was published on 23rd November and there was discussion on the key aspects of that report. The CCO provided an update on Coombe Women and Infants University Hospital (CWIUH) Laboratory Services in terms of Laboratory Operations, Private Samples, National Cervical Screening Laboratory, NCSL Workforce and Projected Activity.

- The CCO also provided an update on the National Screening Strategy and advised that it is intended to be published in early 2023. **Following a discussion, the Committee advised that they would like some of the elements from 2024 to be progressed earlier and** asked that consideration be given to how NSS will measure performance to show improvements are being made. **The CCO agreed to include a response in the CCO report in January.**

- The CCO provided an update on the number of events reported as part of the OEST programme. The CCO explained that maternal events form part of real time shared learning notices. It was confirmed that these shared learning notices will form part of the signals system as part of the Patient Safety Strategy.

- The CCO outlined the key findings of the National Cancer Registry's 2022 Annual Statistical Report, "Cancer in Ireland" and advised that the report further underlines the recommendations for service developments contained in the National Cancer Strategy 2017-2026. The CCO provided a response to the Committee's previous questions as part of his reports on Carbapenemase Producing Enterobacterales (CPE) from the November meeting. An update was also provided on the Public Health Reform Programme. The Chair advised that she will include Public Health on the S&Q Work Plan and invite the ND Public Health to present at the Safety & Quality Meeting in May 2023.

- The CCO advised that progress is on track to deliver an additional 30 WTE consultant appointments by June 2023 in line with commitments under the IR agreement. He also advised that proactive communications and engagement continues to support successful delivery of reform. The CCO advised that the NQPS Division has been successful in securing a grant for its application under Slaintecare to fund the "Quality & Safety Signals Proof of Concept" project to establish an ICT system within maternity services that integrates, analyses and displays quality, safety and operational data.

- The CCO also updated the Committee on the launch of the 'Better Together National HSE Patient Engagement Roadmap' which took place on 6th December and advised that it now sits under Operations. This area is transitioning under integrated operations, and it was agreed that this will be included in the Safety and Quality work plan for 2023. In particular, the Committee requested how outputs will be measured, including KPI's and people's awareness of this important work.

- The CCO advised that OLHN will be progressing to full ambulance bypass on the 14th of December at 9am. Ambulances will bypass to Drogheda, Mullingar and Connolly hospital.

- A meeting has been scheduled with the SAOLTA hospital group in January 2023 in relation to an update on gynaecology services in Letterkenny University Hospital, and the Committee will be provided with an update following this meeting.

- The CCO provided an update on the Interim Model of Care for Long Covid which was finalised in September 2021 to provide follow up services and supports for those experiencing persistent symptoms of Covid-19. He reported that there has been a phased approach to services developed in Post-Acute and Long-Covid Clinics, that several sites

have set up clinics and notification was given to all sites to proceed with recruitment of the resources. The CCO also outlined the key activities and deliverables to date.

6. Internal Audit Reports – Implementation of Recommendations

Robert Morton, Director NAS, Mary Day, ND Acute Ops, Dr. Mike O'Connor NCAGL and Dr. Cora McCaughan, Assistant ND, Internal Audit joined the meeting.

- The NAS Director presented an update on the implementation of the recommendations of the internal audit on "Compliance with the National Ambulance Service Guidance on Patient Non-Transport which was carried out in December 2020. He advised that four Ambulance Stations, namely Cavan, Dooradoyle, Ennis and Ballyshannon, were audited and individual Action Plans in relation to these sites are now in place and being monitored by the relevant senior manager.

- The Committee was informed that actions to address the issues identified, which were put in place since receiving the audit report, were implemented and a Quality Improvement Action Plan to address each of the recommendations has now been completed. Responsibility for oversight of the implementation of the plan has been taken by the NAS Quality & Safety Committee. A subgroup of the NAS Quality & Safety Committee has been established to drive the implementation actions and a training module to address the issues raised with staff and supervisors has been devised and completed.

- The Committee welcomed the update, and it was agreed that the NAS Director would return to the Committee with a further **update in six months' time.**

7. Quality Profile

- The Committee considered the Quality & Safety Profile from the October data cycle as presented by Dr. Healy. A report on the October 2022 workshop was also included. This version of the Quality & Safety Profile includes 7 indicators (3 community and 4 acutes) with service analysis. Further indicators with service analysis will be included in the coming months.

- A Briefing Paper on Quality Profile Report Ambulance Turnaround Times was presented by the ND Ambulance Service, who explained that the current KPI on Ambulance Turnaround Times is being retired for 2023. He explained that it will be replaced with two separate KPIs: "Responsibility of the Acute Hospital"/ NAS Arrival to ED Handover Time and "Responsibility of NAS"/ Patient Handover at ED to Clear. A discussion was had about hospital capacity and the ND explained the three-stage approach being implemented to address this.

- A presentation was made on The Irish Hip Fracture Database (IHFD), which was set up to measure the care for all patients over the age of 60 who suffer a hip fracture. ND Acute Operations talked through the key highlights of 2020 and outlined the key recommendations of the report, which included recommendations for the National Office of Clinical Audit, the Health Service Executive and for Hospital Managers, Clinicians and Audit Coordinators.

- The ND Acute Operations also spoke to the percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 9 hours and advised that there is a large focus on more streamlined access through the system for over 75s. She explained the use of 'FIT' Teams to successfully support this issue and advised that a Learning Day for hospitals has been scheduled for 19th December in Tullamore, for the purpose of sharing knowledge. A discussion was had about the discharge rate from ED and how it compares internationally. A discussion was also had about funding challenges. The Committee suggested bringing the AMRIC team in to present in 2023.

8. AOB

Deirdre Madden

20th January 2023

Signed: _____ _____

Deirdre Madden
Chairperson

Date