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 20th October 2021 at 09.00am via video conference.

Committee Members Present: Prof Deirdre Madden (Chair), Dr Yvonne Traynor, Prof Fergus O'Kelly, Ms Anne Carrigy, Dr Chris Luke, Ms Margaret Murphy, Ms Jacqui Browne.

Apologies: Dr Cathal O'Keeffe

HSE Executive Attendance: Prof Ristead O'Laoide (CCO office), Mr Dean O'Sullivan (CSO), Mr Patrick Lynch (ND GR), Anne O'Connor (COO) Dr Orla Healy, Niamh Drew (Secretary), Pat Galvin, Jaymie Crone.

Joined the meeting: Prof George Shorten (Item 3), Martin McCormack (Item 3), Yvonne Goff (Item 6), Tim Hanly (Item 9), Yvonne O'Neill (Item 7), Gemma Moore (Item 8), Dr Gerry McCarthy (Item 10)

1. Governance and Administration

D Madden took the Chair at 9am and welcomed members to the meeting.

The following items were discussed and noted:

- Minutes of the Meeting on 15th September were approved.
- No matters arose and no conflict of interest were declared.

2. CCO Report

Prof Ristead O'Laoide provided an update of the CCO report and on CAHMS to the Committee. The CCO report included high level updates on the vaccination program, vaccine booster doses, over 65's in long-term residential facilities, cancer funding, management assessment metrics of post-menopausal bleeding and the HIQUA review on the Letterkenny University Hospital and Perinatal Organ Disposal.

In relation to the Covid Vaccination Programme, over 7.35 million vaccines were administered up to the 13th October. 93.4% of the total adult population (over 18) are partially vaccinated and 92.1% are fully vaccinated. Of the eligible population, 91.2% are partially vaccinated and 89.5% are fully vaccinated. We are continuing to see positive outcomes for those people vaccinated with reduction in mortality, outbreaks and disease prevalence amongst those vaccinated, with particular focus on the most vulnerable groups. Third dose vaccinations for immunocompromised persons have begun since Thursday 30th September in hospitals. Vaccinations in CVCs commenced on October 2nd. To date, over 34,000 people have already been identified as immunocompromised on CoVaX, more than 23,600 appointments have been offered, and 9,700 people have received their third primary vaccination. NIAC recommended that a booster dose be given to these cohorts following completion of their primary COVID-19 vaccine course. The booster should be given at an interval of 6 months following the last dose of an authorised COVID-19 vaccine and can be given at the same time or at any interval before or after the seasonal influenza vaccine.

It was noted that there are over 40,000 people over 65 in long-term residential facilities. The booster program for over 65's commenced October 4th. In the first week of boosters around 9,300 were given shots. The aim is that the majority of long-term facilities will avail of the booster shots within a 3 week period.

For funding for Cancer Services 2021, funding for NCCP is crucial with 42 million being requested for 2022. There is currently a backlog of patients to be seen with current focus being on Acute patient congestion. Pandemic Funding is required to keep up the progress.

In relation to Public Health Reform, nursing posts are currently being filled to deal with demand. There are 59 WTE permanent nursing posts as per the 2021 Public Health Pandemic Workforce Plan.56 posts have been accepted, 2 are at offer stage and 1 campaign is underway.

The Committee were given an update of the metric to assess management of Post-Menopausal Bleeding via NPOG HSE Acute Operations and the National Women and Infants Health Programme are advancing a mechanism for monitoring the investigation of post-menopausal bleeding (PMB) upon referral from primary care to acute services. The National Performance Oversight Group have agreed that this is required for Quarter 1 2022. Whilst the revised Clinical Practice Guideline of PMB is being developed (publication expected in Quarter 2 2022), the interim guidance will be reported against. Hospital Groups will be required to account on confirmation of recording of PMB referrals with associated histological activity.

In relation to the publication of the HIQA review on the Letterkenny University Hospital, HIQA have produced a report on the gynaecology services in Letterkenny. The HIQA review acknowledges the significant progress made by Letterkenny University Hospital and the Saolta University Health Care Group in the implementation of the Price Report recommendations. HIQA found that the hospital and Saolta Group were substantially supported and resourced, both financially and with respect to staffing. HIQA recommendation is that 100 consultants in OBGYN is needed. However, areas for further improvement have been identified by HIQA to improve governance structures and processes at hospital level and at Saolta University Health Care Group level. These improvements will be monitored on an ongoing basis.

3. Proposal for new National Learning Analytics Unit

Professor George Shorten and Martin McCormack join the meeting

Professor George Shorten gave a presentation on the proposal for a new National Learning Analytics Unit for health professionals to be established in Ireland. Its purpose is to analyse data from existing and novel sources to identify specific actionable targets which will deliver personalised formative feedback for doctors in training, training programme quality improvement and clinical risk mitigation at hospitals and other clinical sites.

It was noted assessment data of trainees in a postgraduate training programme will have greatest value if they are combined with or examined beside other datasets, such as undergraduate academic performance and training activity The proposal was broken down into 3 main deliverables including an individual trainee being able to access outputs from an aggregate dataset selectively to understand his/her personal patterns of learning or 'blindspots', or performance predisposition. Another being having a programme director who might identify which training interventions deliver the greatest value across a cohort of trainees. Combining such datasets across training programmes offers the potential to accelerate the development of CBMET programmes as effective and efficient training enterprises The third being combining training data with clinical service data such as audits,

registers, clinical incidents, adverse events or “near miss” events which offers the potential to mitigate clinical risk by identifying risk composites.

It was advised that for implementation the HSE would need to be a committed partner in this project. In order to be effective, the collection and dissemination of information must be the responsibility of a national agency that can provide national leadership on learning from errors. The agency should provide analysis and feedback in order to ensure that lessons are learned and models of best practice are implemented effectively. Also for implementation, the planning of health information and HIT developments should be an integral part of the planning of health service developments to ensure that the full potential of health information and HIT to improve patient safety is realised. This should be driven by a patient-centred approach, with full clinical engagement in learning systems design, in order to enable the delivery of health services to the patient in whatever setting.

Professor George Shorten and Martin McCormack left the meeting

4. Structure of new Patient Safety and Quality Office

The ND QPS presented an organogram of the New Patient Safety and Quality Office which consists of a Patient Safety Oversight Group and a National Independent Review Panel. It was explained that this directorate has been around for years in various guises. The development of this division will add QPS Intelligence, Incident Management (NIMS), a Patient Safety Programme and Quality Improvement. The fifth pillar will be a new audit function – AMRIC, which will follow up on reports from National Audit to ensure implementation.

5. Safety and Quality Reports

Professor Orla Healy presented the HSE Quality Profile to the Committee. It was noted all metrics are subject to review by NPOG and the subcommittees of the HSE. The Committee remarked that trends are not going the right way and they were advised that they won't be in the short term due to Covid.

In relation to the percentage of child health & development assessments completed on time or before 12 months of age, the average national performance is worse than the target, with there being a significant reduction in performance from an average of 90.9% up to March 2020 to 45.2% since April 2020. With ambulance turnaround times less than 30 minutes the average national performance is worse than the target with signals of further reduced performance during the past 9 months. For the percentage of patients waiting less than 13 weeks for a routine colonoscopy or OGD following a referral, the average national performance is worse than the target and shows signals of sustained reduced improvement since May 2020. Percentage of patients waiting less than 52 weeks for first access to OPD services, the average national performance is worse than the target and was falling in performance up until March 2021. While the rate has increased in the months since then, it is too soon to determine if it is a signal of improvement. For the percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 6 hours, the average national performance is unstable and worse than the target. There were signals of both improvement and reduced improvement since the beginning of the pandemic.

The Committee advised that a lot of staff were redeployed, and it is hoped that performance will improve in the coming months. Agreed that a quarterly summary report of a more descriptive nature would be supplied instead of the QPS extract from the NPOG report.
An update on Perinatal Organ Disposal was provided stating a letter from the minister on this issue was discussed. The timeline of events was stated and reiterated that parents were contacted by the HSE explaining the details and that this was done by specially trained bereavement support persons. HSE supports were, and still are available for affected parties. The Committee are awaiting a full report to provide more details regarding how and why this incident occurred, and to answer the many questions posed relating to this incident.

In relation to CAHMS, the Cork Kerry Community Healthcare commenced providing appointments to service users this week and such appointments are scheduled from Monday 20th September onwards. This is in respect of service users who would now be adults (over 18). It was noted in excess of 100 appointments have been sent to service users in this first phase. As well as this a Locum Consultant will commence on the 27th September and appointments will be provided to

children under 18, who need both a further clinical need review, as well as providing an open disclosure process. It is intended that the majority of open disclosures plus any clinical reviews required, will be concluded by the end of October.

6. Risk Management

Dean O'Sullivan CSO and Yvonne Goff and Patrick Lynch joined the meeting

The CSO and ND Acute Planning and Strategy provided updates on risk 3 Long-term residential care settings and risk 7 Configuration of hospitals. In relation to Risk 7, the approach to the Risk has improved in the last 2 years. All risks are being reviewed and will be presented to Committee's and the Board in 2022.

In relation to Risk 3, the Risk rating remains the same. The EMT approved the COO's proposal that Risk 3 would be split and a new Risk in relation to Private Nursing Homes be included on the CRR. COVID-19 Response Teams have been established in each CHO area providing a single point of access for a range of supports to all providers (Public, Private and Voluntary). It was noted that an Integrated IP&C control strategy in the community has been developed with particular focus on all nursing homes, public, private, or voluntary. The business case has been submitted to continue supporting the business support team and are funded in the 2022 budget. Key changes to this risk are inclusion of the variant, the vaccination programme, and the booster program. It was noted there are still some nursing homes dealing with outbreaks. A COVID 19 booster vaccination programme is in development which will prioritise residential care. The Committee queried if outbreaks are in vaccinated nursing homes. It was confirmed they are but there are no hospitalisations.

The Committee than were presented with an update of the Risk Register. The Q2 review was completed at the end of June 2021. The Q3 review has been concluded and will be considered by the EMT at its October meeting. The annual full Corporate Risk review has commenced and is expected to be completed in Q4 2021. The first draft Risk Appetite Statement has been considered by the ARC and the EMT. A further draft has been prepared. Once considered by the ARC at its November meeting it will then be submitted to the Board for approval. The recruitment process for a number of new risk roles funded under the NSP 2021 is underway and is expected to be concluded before the end of the year.

The Chair referenced the risk oversight guidance document provided with the Committee papers. This guidance sets out the areas of enquiry the Committee should undertake in relation to risk.

Dean O'Sullivan CSO and Yvonne Goff and Patrick Lynch left the meeting

7. Ard Greine Update

Anne O'Connor COO joined the meeting

The Committee were updated on the Ard Greine. The Minister has been in contact with the families involved. The HSE opinion remains that the Executive Summary should be published. It has not been established whether or not the families wish to see the Executive summary published though as some families who were previously against publication would support publication were it to conclude the incident. The opinion is that the Executive Summary report should be published. Gardai had requested it not be published and this was new information to HSE and only recently made aware. The HSE wrote to Gardai providing the executive summary querying would it be an issue in concluding their investigation. The chronology of events and timeline of conclusion of investigation to be supplied for clarity on the issue as the committee were under a different understanding regarding publication.

Anne O'Connor COO left meeting.

8. Patient Experience – Safe Guarding / 9. Operational Programs - Safeguarding

Tim Hanly joined the meeting

The Committee were presented with a high level video summarising the importance of safe practises and highlighting safeguarding as a pillar of patient safety. A review was carried out in April working to improve Safeguarding Structures. The video shown displayed the abuse that can happen for residents of care homes and how they should approach a solution.

The video is used in peer education and the message is that sometimes there may be times when outside help is needed. It was expressed that empowerment messages are linked to lived experiences. It was noted to the Committee that a further update will be provided approx June 2022

Tim Hanly left the meeting

10. Emergency Medicine Programme

Dr Gerry McCarthy joined the meeting

The Committee were provided with an overview presentation on Improving Patient Flow in Emergency Care. The scale of the challenge, the current practice for managing the handover of patients from ambulance to ED staff, and the evolving projects in the Community and ED to aid with the challenges were presented. It was noted that over 75's attendances in ED is increasing year on year. There is also capacity and infrastructural issues currently in place within hospitals. It was noted that the time of handover from when the ambulance arrives to being transferred to ED staff should be under 20 minutes and the time it takes for the crew to be available to move onto the next incident should be under 30 minutes which in both cases it is currently not. Possible interventions presented were, having virtual consultations, patient care pathways and Outreach Services at pre-hospital levels. As well as reduced triage time for simple presentations, having a senior decision maker available and streaming of pathways at Triage stage. Also optimising clinician hours, improved access to diagnostics and expediting laboratory turnaround at the assessment stage. The Committee thanked Dr McCarthy for an in-depth and informative presentation.

Dr Gerry McCarthy left the meeting

10. Any Other Business

Next Meeting is 17th November 2021

Meeting Concluded at 16:00

Signed: Deirdre Madden _____ **20/10/2021**_____

Deirdre Madden **Date**

Chairperson