HSE Safety and Quality Committee Meeting

Minutes

A meeting of the HSE Safety and Quality Committee was held on Friday 20th October 2023 at 09:00 via video conference.

Committee Members Present: Deirdre Madden (Chair), Jacqui Browne, Cathal O'Keeffe, Anne Kilgallen, Mary Culliton, Anne Carrigy (Joined approx. 12:45).

Apologies: Margaret Murphy, Yvonne Traynor, Fergus O'Kelly.

HSE Executive Attendance: Martina Queally (CO Community Healthcare East), Orla Healy (ND QPS), Sharon Hayden (CCO Office), Niamh Drew (Deputy Corporate Secretary), Rebecca Kennedy (Office of the Board).

Joined the meeting: Maria Lordan Dunphy (AND NQPS – Item 3), Collette Tully (Executive Director NOCA – Item 5), Brian Creedon (Clinical Director NOCA – Item 5), Colm Henry (CCO – Item 6-7), Richard Greene (Director NPEC - Item 6), Pamela Fagan (Chair NIRP – Item 9), Philip Dodd (Clinical Advisor, National Office for Suicide Prevention – Item 10), Lorraine Schwanberg (AND Incident Management – Item 4), Loretta Jenkins (GM Incident Management - Item 4).

1. Committee Members Private Discussion

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

The Chair welcomed executive members to the meeting.

2.1 Declarations of Interest

Anne Kilgallen declared her membership of the Children's Health Ireland (CHI) Board and advised she would leave the meeting during any discussion of CHI.

2.2 Minutes

The minutes of 8th September 2023 were approved

2.3 Workplan 2024

The Committee workplan for 2024 was discussed. It was agreed it would be based on the themes of the Patient Safety Strategy and a draft would be circulated in advance of the November meeting for approval.

2.4 Matters for Noting

The Your Service your Say 2022 Annual Report which was circulated in advance of the meeting was noted by the Committee. It was agreed that the National Complaints Governance and Learning Team should be invited to the Committee in February 2024 to present on how learning from complaints is implemented.

3. National Centre for Clinical Audit (NCCA)

M Lordan Dunphy (AND NQPS) joined the meeting.

Maria Lordan Dunphy (AND NQPS) presented the work of the NCCA to the Committee. She advised that the NCCA was established in response to the HSE National review of Clinical Audit Report in 2019. It is currently strategically and operationally supporting a variety of National Clinical Audits and the development of new National Clinical Registries, which are all at different stages of progression.

Committee discussed the governance arrangements in relation to commissioning audits and the relationship between NCCA and Healthcare audit (HCA). O Healy advised that clinical audits are commissioned through a national steering group chaired by the CCO and that the NCCA is concerned with national audits whereas HCA is local. HCA will feed into national data via the new Clinical Registries.

M Lordan Dunphy left the meeting.

5. National Office for Clinical Audit (NOCA)

C Tully (Executive Director NOCA) and B Creedon (Clinical Director NOCA) joined the meeting

C Tully and B Creedon presented the annual NOCA update to the Committee, highlighting trends emerging from NOCA Audits and audit developments (existing audits & new national audits). Work with the HSE was also highlighted which includes NCCA promotion of clinical audit, the patient safety bill, data collection (Individual Health Identifier (IHI), Integrated Information System data lake (IIS), and interactive dashboards.

The Committee discussed sources of data used by NOCA and the predicted impact of the Patient Safety Act. The Committee also discussed whether NOCA carry out patient experience audit as well as clinical audit. C Tully advised that this is not underway currently but is being considered for future. She also advised that NOCA are conscious of their current acute focus but are aiming to broaden audit scope to community too where future digitisation in services should assist.

The Committee thanked C Tully and B Creedon for the presentation and expressed their continued support for their work.

C Tully and B Creedon left the meeting

6. National Perinatal Epidemiology Centre (NPEC)

6.1 NPEC Annual Report 2021

CCO and R Greene (Director NPEC) joined the meeting

R Greene presented the NPEC Severe Maternal Morbidity (SMM) in Ireland Report 2021 which had been circulated to the Committee in advance of the meeting. The Report covered the NPEC data collection and management process, incidence of SMM in Ireland, trends in major obstetric haemorrhage (MOH), the level of care provided to SMM events, maternal characteristics, neonatal outcomes, recommendations from previous reports that have been progressed, and recommendations from this report.

R Greene highlighted in particular the importance of digitisation in healthcare for clinical audit. He advised that NPEC audits use an online platform now which non-clinical staff could be trained to use. The Committee queried whether data on disabled women's experiences are included in this data.

R Greene advised that it is not currently a characteristic which is recorded and would bring this point back to the audit governance group.

R Greene left the meeting

7. Chief Clinical Officer

The CCO presented his monthly report which covered a number of specific functions of the CCO. In relation to the National Cancer Control Programme (NCCP), the CCO provided a Summary Report on Childhood, Adolescent and Young Adults Cancer. The report highlights an increase in incidence of childhood and AYA cancer between 1996 and 2020 and ongoing significant reductions in mortality, reflecting advances in early detection, treatment, and care. It was agreed that the CCO would provide data on how rates of cancer in young adults in Ireland compare internationally

The CCO updated the Committee on progress made in relation to the Unscheduled Emergency Care 3 year plan which is part of new Urgent and Emergency Care Programme that has followed best practice in health service and system improvement and comprises of national and local plans. The Committee discussed whether this will include 7 day service for senior decision makers. The CCO advised that the new consultant contract allows 6/7 working with maintaining flow through hospitals a key priority.

The CCO presented a number of Committee Requested Updates. He advised that in relation to Our Lady's Hospital Navan (OLHN), meetings have progressed to agree a change of governance under the new regional structure and to understand a recommended date for progress to the final phase to a Model 2 hospital. The Committee queried whether there has been an impact on walk in attendance rates at OLHN ED which the CCO agreed to provide data on.

A Kilgallen left the meeting approx. 12:25

The CCO updated the Committee on the ongoing CHI Reviews, advising that CHI published the collated CHI report on the 18th of September and the internal and external review, the Boston report, on 20th September. The HSE Independent review commenced the week of 2nd October and the CCO confirmed that engagement with families and advocacy groups has been a priority. Following queries from the Committee, the CCO confirmed the review will be multi-disciplinary in nature and outlined its

aims and objectives. He also agreed to provide the TOR of the HIQA serious incident review when these are available of the use of the non-medical grade springs in CHI at Temple St to the Committee.

The CCO reported to the Committee on a number of the other areas set out in the report including:

- Covid-19 Test and Trace - Future Operating Model
- Prescribing process for Cariban®
- National Newborn Bloodspot Screening and National Universal Hearing Screening Programmes
- National Women and Infants Health Programme's Obstetric Event Support Team Programme
- National Screening Services

CCO left the meeting and A Carrigy joined the meeting

8. Quality Profile

The Committee considered the Quality Profile from the August data cycle. O Healy updated the Committee on the monthly indicators, noting that there was very little change by comparison to July indicators. It was agreed a workshop on the quality profile will be included as part of the January 2024 Committee meeting

9. National Independent Review Panel (NIRP)

9.1 Introduction to new NIRP Chair

P Fagan (Chair NIRP) joined the meeting

The Committee welcomed the new NIRP Chair P Fagan to the meeting.

P Fagan advised the Committee that her background for the past number of years is in QPS and that her approach focuses on the learning coming from reviews. She advised that she will be reviewing the function of the NIRP shortly and would welcome engagement from Committee members on this.

The Committee thanked P Fagan for her introduction and fully supported her focus on learning, emphasising that the implementation of recommendations from reviews need to be monitored closely.

P Fagan left the meeting

10. Suicide and Health Care

10.1 Irish Probable Suicide Deaths Study in Ireland between 2015 – 2020, HSE & Establishment of a National Suicide Registry

P Dodd (Clinical Advisor - National Office for Suicide Prevention) joined the meeting

P Dodd presented the National Confidential Inquiry into Suicide and Safety in Mental Health: Completeness of data and the profile and circumstances of mental health service users who died by probable suicide between 2015 and 2020, which was circulated in advance of the meeting, to the Committee. The report was presented by National Quality & Patient Safety Directorate in collaboration with the National Community Mental Health Directorate as an example of working in partnership with colleagues in the community to improve quality & safety and improve Common Causes of Harm.

P Dodd advised the Committee that based on evidence from studies of mental health services, primary care and accident and emergency departments, a list of 10 key elements for safer care for patients has been developed. The Committee discussed the data used (Central Statistics Office and Mental Health Commission) in its project and its limitations and discussed the potential for more data to be gathered by the HSE from the National Incident Management System (NIMS).

P Dodd and C O'Keeffe left the meeting

4. Patient Safety Together

4.1 Sharing Learning and Improving - An interactive update on the Patient Safety Together Platform

L Schwanberg (AND Incident Management NQPS) and L Jenkins (GM Incident Management) joined the meeting and A Kilgallen re-joined

L Schwanberg updated the Committee on the Patient Safety Together Platform web based platform designed to provide up to date QPS info to support learning. She advised that the project focused on sharing lessons learned from incidents initially but it is intended that other patient safety sources will further inform the work (e.g. international resources, coroner's recommendations, patient experience).

The HSE website page with the information is accessible to all and the content development and administration of the website page is overseen by the QPSIM staff. The Committee expressed their continuing strong support for the project and agreed that an evaluation of Patient Safety Together should come to Committee when completed in early 2024.

L Schwanberg and L Jenkins left the meeting

AOB

No matters arose under this item.

The meeting ended at 15:12.

Signed: Deirdre Madden **16 November 2023**

Deirdre Madden
Chairperson **Date**