

Commission on Patient Safety and Quality Assurance

Minutes of 10th meeting

15-16 November 2007

Summary of Action Points

	Action	By whom	Deadline
1	Prepare composite list of values/principles that should underpin the Report	Chair	Circulate before next meeting
2	First draft of outline framework document for report	Chair	Next meeting
3	Submissions to be read, summarised and analysed.	Chair to prepare summary. All members to read	Next meeting
4	Invite the Competition Authority to meet the Commission on licensing in 2008.	Chair	
5	Subgroup reports to be produced Circulate	Chair of each subgroup Secretariat	ASAP

Commission Members in attendance:

Chair: Dr. Deirdre Madden, Senior Lecturer in Law, University College Cork
Dr. Richard Brennan, General Practitioner, Kilkenny
Dr. Eibhlín Connolly, Deputy Chief Medical Officer, Dept of Health and Children
Ms. Edwina Dunne, Head of Quality & Risk, HSE
Ms. Mary Duff, Director of Nursing, St. Vincent's Hospital
Prof. Muiris X. FitzGerald, Physician
Mr Paul Fox, Process Engineering Manager, Bausch and Lomb, Waterford
Dr. Mary Hynes, Director of Quality and Risk, National Hospitals Office, HSE
Dr. Alf Nicholson, Consultant Paediatrician, Our Lady of Lourdes Hospital (Sub-group morning session)
Mr Tiberius Pereira, Patient/Carer Representative, Dublin
Dr. Ailis Quinlan, Clinical Indemnity Scheme
Dr. Gabriel Scally, Regional Director of Public Health, NHS
Mr Dermot Smyth, Assistant Secretary, Department of Health and Children

Secretariat:

Mr. Luke Mulligan, Department of Health and Children
Ms. Susan Reilly, Department of Health and Children
Ms. Elaine Tallon, Department of Health and Children
Ms. Ailish Corr, Department of Health and Children

Documentation:

Discussion paper on "The role of Clinical Audit" prepared by Ms. Hilary Coates

Discussion paper on “The role of Incident Reporting and Learning” prepared by Ms. Debbie Dunne.

Discussion paper on “Governing bodies in the healthcare system” prepared by Dr. Paul Kavanagh

Discussion paper on “Licensing Healthcare Providers” prepared by Dr. Aidan Ryan and Dr. Deirdre Mulholland

Introductions

The Chair opened the meeting and thanked those in attendance. In particular, she thanked the researchers for their work and continued support.

Agenda Item 1 – Apologies

Dr. Tracey Cooper, CEO, Health Information and Quality Authority

Mr. Tim Delaney, Head of Pharmacy, AMNCH

Ms Margaret Murphy, Patient/Carer representative, Cork

Agenda Item 2 - Minutes of Previous Meeting / matters arising

The minutes of the last meeting were agreed. A note of the meeting with the Mental Health Commission will be circulated when cleared by them.

Plenary I – discussion on values/principles that will underpin the Report of the Commission

Each of the sub-groups gave a summary of the areas covered by them during the day and the issues that arose.

Sub-group 1 concentrated on agreeing values, dealt with issues around protected disclosure and the need for benchmarking to International Standards, as well as the requirement to keep all initiatives patient-centred.

Subgroup 2 worked on clinical audit and how to get the most out of incident reporting that would facilitate learning.

Subgroup 3 and 4 looked at the need for equity, excellence throughout the service wherever it is delivered and the value of regulation that must be necessary, effective, fair and proportionate.

It was agreed that patient participation in planning (at Service/HSE level and hospital plans) is also important. There will be team and individual roles in any service delivery but there must also be ownership and accountability.

Plenary II – Review of Research Paper from all subgroups

Sub-group 1

A comprehensive presentation was provided outlining the results of the research work of sub-group to date. Sub-group 1 looked at each of the principles agreed at previous meetings i.e.

- Knowledgeable patients – should be better knowledge throughout the population on how to prevent and manage conditions, access to good information on-line will become more important in the future.
- Skilled Professionals – the right group of professional carers e.g. specialists in emergency medicine working in A&E.

- Effective treatment –encompass the broad notion of total treatment care package including treatment, equipment, follow-up e.g. physio
- Appropriate environment
- Assessed outcomes -patient feedback required on outcomes

A number of issues were raised in the course of the discussion.

- Someone in charge for Quality and Safety
- Need for training programmes to produce skilled CEOs
- Gap in governance between hospitals and community care at management level
- Health technology assessment on existing and new drugs to reflect international approach quickly
- Strategic overview of all diseases (e.g. cancer programme)
- Examples of best practice in continuing professional development in other jurisdictions to be reviewed
- All avoidable deaths must be recorded and learned from
- Surgery – set time in morning for emergency cases that present at night.
- When standards for effective treatment/care are published the onus will be on the provider to ensure action plans are implemented

Sub-group 2

Clinical Audit / Incident Reporting

These discussion papers define, describe and appraise the role of Clinical Audit / Incident Reporting in a system of management for the delivery of a health service that would see informed patients receiving care from skilled professionals providing effective treatment in appropriate environments with assessed outcomes.

Clinical Audit

This paper describes the system of clinical audit for public health care providers and services in the following jurisdictions

- UK
 - England
 - Scotland
- United States
- Australia
- Denmark
- Norway

The following points were noted:

- Clinical audit has an important role to play in assuring the quality and safety of care for patients;
- It provides a powerful mechanism for ongoing quality improvement, highlighting incidences of when standards are not met and identifying opportunities for improvement;
- Features associated with successful audit are clinical leadership and management support;
- Many clinicians have fears about participating in any quality and safety activity because of the fear of punitive accountability + litigation: a just and fair culture should be encouraged with built-in protection for disclosure;

- Clinical audit has traditionally had a low priority within the health services in comparison with other activities e.g. research often has rewards such as protected time, funding and publications;
- Clinical audit should not be a stand alone function within an organisation but should be considered within an integrated Quality & Safety framework;

Issues for decision by the Commission include:

- Should protective legislation be considered for activities with the sole purpose of improving patient safety & quality?
- How to balance the public right to access to information and the public interest in removing barriers to participation by clinicians and healthcare organisation in effective safety and quality activities;
- Should organisations or clinicians who qualify for qualified privilege commit to publicly publishing risk-adjusted, clinician validated aggregated information about clinical audit.
- Should 'Protected' time for some elements of clinical audit be considered;
- Universal patient registration?
- Should audit results and improvement plan to be published?
- Incentives/sanctions/mandatory?

Incident Reporting

This paper defines and describes Incident Reporting and Learning Systems and its role in assuring the quality and safety of care for patients. WHO define patient safety incidents as “an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient,” and adverse event as “an incident which results in harm to a patient.”

The following jurisdictions were reviewed:

- UK
- United States
- Australia
- Denmark

The following points were noted during the subsequent discussion:

- The primary purpose of incident reporting is to learn from experience of adverse events or near misses to reduce or prevent patient injury or harm;
- Currently there is no pathway for patients to report adverse events/incidents;
- Incident reporting is just one method used to establish the patient safety profile of an organisation. Others include complaints history, brainstorming, claims history etc.
- Incident Reporting should be considered within an integrated Quality and Safety framework;
- A Reporting system should allow for anonymous reporting and include comprehensive audit trails;
- It is essential that the lessons learnt in one healthcare establishment are communicated regionally, nationally and internationally;
- Effective reporting to include primary and community care as well as pharmacies, public and private sectors;

- Reporting of near misses, triggers, etc. essential.
- Deliberately giving wrong information (especially under protection) must be regarded as a serious offence.

Issues for decision by the Commission include:

- Should there be a single Reporting and Learning Platform?
- Should reporting of adverse incidents/near misses be mandatory? – What sanctions for failure to report?
- Should incident reporting be linked to licensing?
- Should there be a single co-ordinating agency? or concordat between existing agencies
- Levers for measuring quality and safety

Plenary III

Sub-group 3

Governing Bodies in healthcare system:

This paper described and critically appraised the system for regulation of health professionals in the Republic of Ireland, with reference to the approach taken in other jurisdictions, so as to inform recommendations made by the Commission in the area of “*the governance of regulatory bodies in the health care system and ways in which effective integration can be enabled between the various bodies*”. Other jurisdictions looked at were UK, USA, Canada, Australia, Finland and the Netherlands.

The following points were noted during the subsequent discussion:

- Self regulation has been a feature in health professions in most jurisdictions.
- Many systems are moving away from self-regulation for health professionals to one where there is greater lay involvement.
- Regulation of health professionals in Ireland is already changing – arising from high-profile incidents exposing failures in care and potential weakness in professional regulation.
- Governance of professional regulation is moving towards a model where bodies have a lay majority and where members are appointed rather than elected by peers.
- Unsafe and poor quality care can arise for one of two fundamental reasons: human error in the context of a weak system and poor performance of health professionals. In securing safety and assuring the quality of health care, professional regulation has become a focus of health system reform internationally.
- There is evidence to support extension of licensing and registration to non-medical professionals improves patient outcomes.
- Certification and re-certification to assure maintenance of competence is also supported by evidence as an effective intervention.
- Credentialing is a popular intervention in the US and is of interest to other systems; however an evidence base regarding its impact is yet to accumulate.

Issues for decision by the Commission include:

- Is there a need/role for an overarching body in the area of healthcare regulation which would harmonise and coordinate health profession

regulators? – should a new ‘stand alone’ body be established or should an existing body be enhanced?

- Should credentialing be used as a professional regulatory intervention in Ireland – which processes of care should be the subject of credentialing - should it be piloted and evaluated?

Licensing & Accreditation

This paper is a preliminary research document as the research process is ongoing. It describes the system of licensing for public and private health care providers and services in the following jurisdictions

1. Ireland
2. Australia/New Zealand
3. Canada
4. Netherlands
5. Malaysia
6. United Kingdom

The main questions in relation each jurisdiction were

1. What licensing/accreditation systems are in place in each country?
2. What was the context under which the system was established?
3. Is there any evidence of effectiveness of the systems?

The role of regulation is to provide assurance that systems for quality and safety are in place and working well. Regulation of healthcare providers and organisations are therefore important to patients, users of healthcare services, and the wider public. It was noted that it is difficult to find robust evidence to show that licensing will make institutions safer for patients. However, it can be a mechanism for change. Some of the benefits of licensing identified were:

- Preventing providers entering the healthcare system without proper governance etc.
- Reassurance to patients.

The following points were noted during the subsequent discussion.

- Any recommendation on licensing must comply with National and EU Competition Law if appropriate: It was agreed that the Competition Authority will be invited to meet the Commission in the New Year;
- Need to look at the operational elements of licensing e.g. equipment, imaging, staffing, training etc.
- Where does licensing fit with primary care – GPs registered with their professional bodies but what about premises, equipment etc.
- Model recommended should be piloted.
- Sanction and enforcement – withdrawal of licence. Implications of closure i.e. transfer of patients.
- Appeal mechanisms.

Issues for decision by the Commission

- Is a licensing system necessary? – what model most suitable for Ireland
- Should it be mandatory? - linked to minimum standards which are set out on statutory basis; linked to clinical and non-clinical audit and adverse event reporting?

- Should it cover public and private facilities?
- Whether licensing should be hospital-wide (one licence for whole hospital), or specific departments within hospitals or for core functions
- Who should be the licensing/accreditation body? i.e. Ministry of Health, Government agency, Independent body;
- Who should be the enforcing body for licensing;

Plenary IV – Discussion on structure of report and work programme

The following points were noted in relation to the structure of the final report:

- A small drafting group should be established to include Chair of Commission, chairs of each sub-group and secretariat to coordinate preliminary draft;
- Identify target audience i.e. public/professional – balance required between both groups;
- Executive summary to include vignettes – identify patient journeys already in the public domain;
- Chapter on “what we heard”: acknowledge submissions, identify common themes and agree mechanism to incorporate into Report;
- Chapter on current service in relation to safety and quality: identify gaps and suggest means to close these gaps;
- Identify values & principles that should underpin the Report and how these should be realised;
- Chapter on how recommendations should be implemented and who should monitor implementation;
- Recommendations:
 - Evidence-based and linked to research findings, where possible;
 - Linked to submissions, where possible;
 - Time-frame for implementation of recommendations.
- Lessons learned from previous reports e.g. O’Malley, Galway, Barringtons, Portlaoise, Lourdes should feed into Commission Report.

Work programme for the New Year:

It is anticipated that all research documents will be complete by December. It was agreed that there will be another two-day meeting, possibly in March. There may be an earlier commencement time for meetings in 2008.

Next meeting

Friday 14th December 2007 –

Venue: Conrad Hotel, Dublin 2

Meeting: 9.30am – 2.00pm

Lunch 2.00m – 4.00pm

Signed _____

Dr Deirdre Madden
Chairperson

Commission on Patient Safety and Quality Assurance

Date _____