Tallaght Hospital

Implementation Steering Group (ISG)
HIQA Report

2015 Update on Implementation of HIQA Recommendations

Contents

1. Introduction

On 17th May 2012, the Health Information and Quality Authority (HIQA) published its report into the quality, safety and governance of care provided to acute patients admitted to Tallaght Hospital. This report was concluded following an 11 month inquiry into matters covering scheduled and unscheduled patient access into the hospital, with a particular focus on the hospital's leadership, governance and management processes. The HIQA report also focused on oversight arrangements in place for the hospital within the HSE.

The Board of Tallaght Hospital established a Board Committee entitled the Implementation Steering Group (ISG) for the HIQA Report in June 2012 to oversee the implementation of the HIQA recommendations within the hospital's remit and to advise the Hospital Board on the wider recommendations whose implementation is under the remit of the Department of Health, HSE or SDU.[1]

On the 30th of April 2014, Tallaght Hospital published on update on progress against recommendations which were still being implemented. This paper provides a more recent update.

There are 76 recommendations in the HIQA Report. Only 7 of these are local recommendations which relate specifically to Tallaght Hospital, 5 of which are within the remit of the hospital and 2 of which are matters for the Department of Health. A further, 43 national recommendations are to be implemented by all hospitals, including Tallaght, with the remaining 26 national recommendations falling under the remit of the Department of Health (DoH), Health Service Executive (HSE) or Special Delivery Unit (SDU). Accordingly, a total of 48 recommendations (5 local and 43 national) are required to be implemented by Tallaght Hospital and are the focus of this update.

Many of these HIQA recommendations have been brought to the point where they are now incorporated into the normal working of the hospital's governance, leadership, management and clinical processes; with implementation of the remaining recommendations well underway.

The primary objective for Tallaght Hospital is to deliver safe, dignified and high-quality care through the best utilisation of resources. It is generally recognised that considerable improvements have been achieved by the Board, Executive Management Team, clinical leaders and staff of Tallaght Hospital in governance, executive functioning and clinical operations since HIQA commenced its inquiry. These changes have been implemented and sustained despite a reduced financial allocation and a reduction in headcount with the consequent need to implement efficiencies and significant costs savings.

[1] The SDU has since been stood down.

2. Implementation Plan (HIQA Report) for Tallaght Hospital. Background

The Implementation Steering Group (HIQA Report) when established in June 2012 reviewed and endorsed a draft implementation plan developed by the Executive Management Team.

This plan involved developing an index/reference list of the 76 HIQA recommendations and categorising the recommendations into two core groups, as follows:

1. 48 recommendations within the hospital's remit, both specific to the hospital (local) and relating to hospitals generally (national); and
2. 28 recommendations under the remit of agencies such as DoH/HSE/SDU.

The Steering Committee also stipulated a governance and accountability structure, including the named individual (executive or non-executive director) or group (committee or team) responsible and accountable for the implementation of each recommendation relevant to the hospital.

The hospital sought and received written confirmation from Dr. Philip Crowley, HSE National Director for Quality and Patient Safety, endorsing the hospital's assumptions of their responsibility to implement the 48 recommendations identified as relevant to the hospital. The other 28 recommendations fall outside the remit of the Hospital. The HSE has responded confirming the approach and assumptions made by the hospital.

Update on Implementation Plan

The remainder of this update will focus on progress made on the 48 recommendations within the remit of Tallaght Hospital. These are presented in four groupings, as follows:

1. Local (Tallaght Hospital specific) recommendations
2. national recommendations under the Board's remit
3. national recommendations under the Executive Management Team's remit
4. national recommendations under the Emergency Department's remit

The hospital recognises that the delivery of safe, dignified and high quality care is an ongoing process which requires continuous focus: to that extent many of the recommendations are of an ongoing nature and cannot ever be regarded as complete. The approach taken by the hospital in implementing the recommendations reflects a combination of continuously embedding robust systems and processes, ongoing vigilance and an open proactive learning culture. This focus on continuous improvement is reflected in the decision to prepare and publish this further update.

3. Update on implementation of local HIQA Report recommendations which are a matter for Tallaght Hospital

Of the 76 recommendations in the HIQA report, there are seven local recommendations which relate specifically to Tallaght Hospital, five of which are within the remit of the hospital to implement and 2 of which are matters for the Department of Health.

This section provides an update for each of the **five local recommendations** under the remit of Tallaght Hospital. It is recognised that many of the recommendations are of an ongoing nature and cannot ever be regarded as complete. From this perspective, the hospital provides a response below to highlight what is in place with respect to each of the five recommendations and, where appropriate, identifies further actions which are planned.

3.1 HIQA Recommendations Specific to Tallaght Hospital

This section provides an update on implementation of those **five recommendations** which were specific to Tallaght Hospital

HIQA Recommendation	Actions to Date	Future Planned Actions
1. The Hospital's operational and executive management structures, with the assistance of the National Emergency Medicine Program (NEMP), should have the necessary arrangements in place to implement the NEMP. The executive must provide periodic assurances to the Board of the Hospital regarding the quality, safety and timelines of unscheduled patient care delivered at the Hospital.	An Unscheduled Care Governance Group has been established which drives and oversees the changes required to ensure compliance with the NEMP. The focus to date has concentrated on reducing non-admitted waiting times (i.e. the number of patients attending ED who are seen and discharged within six hours). Data on the quality, safety, access to and timeliness of unscheduled patient care are presented to the Executive Management Team (EMT) and the Board on a monthly basis. A major capital project commenced in December 2013 to expand the physical capacity of the hospital's Emergency Department (including the development of an Initial Assessment and Treatment Unit). Phase 1 of the building project for the Emergency Department was completed in December 2014. Phase 2 is near completion with an expectation to handover to the ED staff in June 2015. In total the project will have increased space in the ED by 33% resulting in an increase in major cubicles by six, ambulatory care cubicles by five, initial assessment areas by two and an increase in isolation rooms and Resuscitation Bays by one. Although contingent on factors other than increased space alone, it is anticipated that this will lead to a 20% improvement in six hour and a 15% improvement in nine hour Patient Experience Times for Non-Admitted Patients.	As part of the Hospital's ongoing quality improvement programme, patient flow has been prioritised with focus on improving access for patients and enhancing their hospital experience. There is on-going work in this area under the national Irish Hospital Redesign Programme (IHRP). The IHRP selected Tallaght to be its pilot site. The 10 projects selected will deliver improvements in emergency and elective patient pathways.

HIQA Recommendation	Actions to Date	Future Planned Actions
2. The Hospital must engage fully and effectively with the range of stakeholders, including general practitioners, in order to ensure the most effective referral process for patients. This should be monitored and evaluated on an ongoing basis.	The Hospital has a GP Liaison Committee which supports the introduction of projects to improve the referral process from GPs. For example, all local GPs have been notified to inform them of the Acute Medical Admission Unit (AMAU) and how to make referrals to this service. Separately, a number of meetings and study days are organised with our local GPs to improve partnership working. In addition, there are GP representatives on many internal hospital projects, such as the OPD Referral Project. An electronic referral solution is now in place for most Paediatric areas. This has led to a more streamlined referral process and enhanced data capture with a the full programme for implementation due to conclude by Dec 2015	There is on-going work in this area. Specifically, there are plans to extend the electronic referral solution to certain adult services in 2015 with our ED currently piloting an electronic discharge letter for GPs. The hospital is currently working on redeveloping its Internet site which is due to be launched in Quarter 4. The redeveloped site will build on the existing information provided to GPs with regard to the clinics we run, the specialities and consultants associated with same, patient information leaflets along with information on the Continuous Professional Development opportunities available to them from our Centre for Learning & Development. In addition, we are planning to launch a new GP Newsletter this year which will have content similar to that available on our Internet.

HIQA Recommendation	Actions to Date	Future Planned Actions
3. The Hospital should ensure that all initiatives taken to improve the efficiency and effectiveness of the Outpatient Department's 'Did not Attend' rate should be monitored to measure their impact, and to identify any areas where additional gains may be achieved.	Tallaght Hospital has a system in place where DNAs (Did not Attends) are tracked monthly and reported through the Clinical Directorate structure. Other measures are in place to reduce DNA rates including text message reminders to patients of OPD appointments. A new Out Patients Policy has been developed which reflects the National Protocol. Weekly reports are now being sent to all clinicians/team leaders outlining their Referrals, OPD Patient Attendances and DNA's . Chronological booking is in place. Continuous improvement plans to maintain the validation of OPD waiting lists is underway. This includes the development of a LDDI screen on iPIMS to record all validation details.	There is ongoing work in this area. The hospital is continuously reviewing its operational processes to ensure that a systematic approach to chronological booking is in place. As part of this, a centralised OPD office is being developed under IHRP.
4. The Hospital should formally review and validate the patient waiting lists for diagnostic imaging on an ongoing basis and establish a prioritisation process with appropriate monitoring mechanisms.	Requests for radiology are clinically vetted and prioritised and waiting lists are validated on an ongoing basis. The Radiology department have developed a standard operating procedure for the validation of diagnostic imaging waiting lists. This has being piloted since January, 2015 on the MRI waiting list with a view to rolling out across all areas.	As part of a wider quality improvement programme there are projects focussed on this area. Specifically, there is ongoing executive management focus to ensure that there is an iterative process of validation. In addition, a suite of diagnostic KPIs are in development.
5. The Hospital should have effective arrangement in place to manage and monitor the utilisation of the Clinical Decision Unit (CDU) in order to ensure that the length-of-stay timeline for patient is less than 24 hours.	CDU utilisation and length of stay is been studied by the Medical Directorate and as per the NEMP (National Emergency Medicine Programme). Arising from this review the future capacity and specific role of the CDU will be decided.	Various options for the use of the current bed stock in the CDU are being investigated including a review of the value from allocating greater capacity to the AMU. As part of this, a pilot has begun to review the benefits from developing a new Surgical Assessment Unit. These options are being considered as part of the Irish Hospital Redesign Programme in conjunction with the ED capital expansion project.

3.2 National HIQA Recommendations under the remit of the Board of Tallaght Hospital

The Board is responsible for implementing **21 national recommendations** arising from the HIQA report.

The Board comprises 11 Members including the Chairman. However, as a matter of practice and save in exceptional circumstances, the Chief Executive and appropriate members of the EMT attend and participate fully in all Board meetings. This is designed to ensure, on the one hand, that Board Members are fully aware of the practical impact on the hospital of their decisions and, on the other hand, that the EMT is fully aware of the governance and other requirements of the Board. The aim is to achieve a corporate approach by all concerned. Decisions are taken by consensus involving both the Board Members and the members of the EMT but, should a vote be required, voting is confined to Board Members. All members of the Board are equally responsible for implementation of the 21 recommendations but the Chairman carries a particular responsibility in this regard.

On its establishment in December 2011, the new Board adopted and started to implement contemporary governance policies, processes and practices which were subsequently reflected in the recommendations of the HIQA Report when published in May 2012. These covered issues such as Board membership; competencies and skills of Board members; induction and ongoing self-evaluation; clarify of roles and remits; and declaration of interests. Since the HIQA Report, the Board have progressed on implementing a protected disclosure/whistle blowing process for staff and a programme for patient advocacy and service user engagement. The agenda for, and minutes of, every Board meeting are published on the hospital's website.

The new Board policies developed in December 2011 were reviewed and updated at the Board's subsequent annual review meetings. The Board Committee structure was reviewed with each of the committees' terms of reference being reviewed and updated. The reports submitted by the executive to the Board have been revised to ensure that timely data on quality, risks, financial and operational activity are presented in a concise yet useful manner to assist with compliance with the Board's accountability remit.

The following schedule provides a specific update on each of the 21 recommendations.

HIQA Recommendation	Actions to Date	Future Planned Actions
1. All health and social care service providers in receipt of State funds should ensure their compliance with the *Code of Practice for the Governance of State Bodies*.	This recommendation is now reflected in the HSE Annual Compliance Statement which the hospital, along with other section 38 providers, is required to complete each year. An up-to-date and comprehensive corporate governance manual has been completed and adopted by the hospital Board	
2. All health and social care service providers in receipt of State funds should come under the remit of the Comptroller and Auditor General and should be compliant with all directives from the Departments of Finance and Public Expenditure and Reform (particularly in relation to finance, procurement and staffing).	The question of extending the remit of the C&AG is not within the remit of the hospital but the hospital has a robust system in place at Board and executive levels to ensure compliance with all directives from the Departments of Finance and Public Expenditure & Reform. The hospital completed implementation of a contemporary financial management system (SAP) in 2013. We are now in the process of implementing a new HR and payroll system (SAP HR) which a plan to release in July 2015.	
3. A mechanism should be established through which Foundations, Trustees and other community stakeholders, can continue to be involved in the development of hospitals in a non-governing and non-managerial way.	There have been regular meetings with the hospital's foundations to develop their role and relationship with the hospital.	Further proposals in this regard are being developed for consideration by the Board.

HIQA Recommendation	Actions to Date	Future Planned Actions
4. Existing board should undertake an assessment of the composition, competency, profile and potential conflicts of interest of board members and make the necessary changes required to ensure that the board is constituted appropriately and in accordance with modern day corporate governance of boards and the recommendations contained in this Report	The board was reconstituted in December 2011 following the commencement of the HIQA investigation and a letter from HIQA to the Minister of 18 November/ 2011. The size of the Board was increased from nine to 11 under new bye-laws made by the Board, with the agreement of the three foundations, in November 2014.	The nomination of two additional members to the Minister will be considered by the Board when it has completed an externally facilitated review of its effectiveness which is currently underway.
5. A mandatory board induction program should be in place for all new board members, and executive directors, covering such topics as the role and responsibilities of a board member, the role and responsibilities of executives, corporate and clinical governance, financial oversight, ethics and business conduct and their roles and responsibilities in achieving board objectives specific to the organisation.	There is an induction program in place for new members which is facilitated by the Chairman, Board Secretary and Chief Executive.	
6. There should be a mandatory ongoing development programme for board members, informed through the annual self-evaluation of the effectiveness of the board, covering topics such as emerging governance issues and practices, quality and safety and financial management as well as more detailed information on organisation-specific issues.	Annual self-evaluations of the effectiveness of the Board have been undertaken in recent years.	The Board is currently conducting an externally facilitated review of its effectiveness. The Governance Committee is due to review Board member training and development later this year as part of its work programme.

HIQA Recommendation	Actions to Date	Future Planned Actions
7. The role and functions of boards must be clearly defined and the board should: - ensure that there is an effective management team in place - oversee the development of, approve, and monitor the implementation of the hospital's strategic plan - ensure that there is an effective code of governance in place that is subject to ongoing review - require the executives to produce concise, understandable and relevant information that demonstrates that the hospital is achieving its strategic objectives, effectively managing its available resources and providing good safe care - challenge the executives of the hospital when it is not clear that the hospital is achieving its objectives, and hold executives accountable for performance - provide assurances to the public that the service is managing its resources to provide sustainable, safe, effective person-centred care	These are currently the functions of the Board (either directly or delegated through the Board Committees) and documented in the Corporate Governance Manual which was approved by the Board in November 2014. Currently, there are four Board Committees as follows: - Audit Committee - Quality, Safety and Risk Management Committee - Remuneration and Terms of Service Committee - Governance Committee Monthly reports are presented to the Board for activity, finances and quality, safety and risk management. These include KPI reports on activity & quality and patient safety indicators (including crude mortality).	The number of Quality and Safety KPIs reported to the Board is continually increasing as data quality improves. The hospital's processes for reviewing and learning from mortality data are currently being updated with a new hospital wide mortality committee due to be established in Quarter 3 2015. A clinical services prioritisation strategy is currently being developed.

HIQA Recommendation	Actions to Date	Future Planned Actions
- oversee and approve the development of the hospital's quality, safety and risk management plan and regularly evaluate the hospital's risk register and risk management activities - monitor rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the hospital, and also inform action that may be required to improve outcomes for patients. - Board members should understand their fiduciary duty to act as members of the board of an organisation and not representatives of any group - their equal responsibility for the consequences of the board's decisions, actions or non-actions the need to support and abide by decisions made by the board even if, as individuals, they did not participate in the decision or did not agree with the decision.	These requirements are included in the induction process and the governance documents developed by the Board including the Standing Orders, Scheme of Reservation and Delegation and the Standing Financial Instructions. The issue of collective corporate responsibility is accorded a very high priority by the Board.	
8. There should be a register of interests in place in relation to individuals with potential and/or actual conflicts of interest, in accordance with the requirements of the Ethics in Public Office Act that includes board members and employees of the hospital and those with other relevant conflicts of interest. This should be subject to no less than annual review by the chairperson and chief executive.	A register of interests is submitted by Board Members each year and held by the Board Secretary. Relevant employees outlined in the Ethics in Public Office Act are informed of their responsibility to submit a declaration of interests annually to the Standards in Public Office Commission.	

HIQA Recommendation	Actions to Date	Future Planned Actions
9. There should be an effective process in place for board members to declare potential and/or actual conflicts of interest whilst conducting board business that would allow the chairperson and board secretary to consider for themselves if there were agenda items that might possibly present a conflict of interest for any member of the board. All potential and/or actual conflicts that arise and decisions in relation to them should be documented.	The requirement to disclose any conflict of interests is a standing agenda item at the start of each Board meeting. .	
10. Boards should oversee and support the building of strategic partnerships with other stakeholders, including community organisations, primary and secondary care providers, in order to achieve the organisational objectives and to ensure that the organisation does not operate in isolation of the national and local system for the delivery of care and support to its population.	A Patient Advocacy and Service User Programme has commenced with community representatives, patient advocates and service users involved in capturing feedback on patients' experience and engagement on service planning. A GP Liaison Committee is in place and meets monthly. Strategic partnerships are in place with Trinity College Dublin, the Coombe Hospital and St. James's Hospital through Trinity Health Ireland. There is also a strategic partnership in place with Peamount Healthcare.	There is an ongoing series of meetings with the Chairs, CEOs and clinical leads of the member hospitals of the Dublin Midlands Hospital Group as well as with members of the Children's Hospital Group Board.
11. A clear scheme of delegation of accountability from the board to chief executive and executive directors should be in place. This should include unambiguous delegated executive accountability and responsibility for the quality and safety of patient care.	This was put in place in January 2012. The duties and responsibilities of the chief executive are listed in the code of governance which forms part of the Corporate Governance Manual.	

12. The board should ensure that the scheme of delegation for critical decision-making, including financial thresholds and policy decisions is clear and unambiguous and is subject to no less than annual review by the board.	A revised Schedule of matters reserved for Board decision was approved by the Board in November 2014 as part of the Corporate Governance Manual.	
13. The business of boards in receipt of State funds should be conducted openly and transparently. All boards should host the maximum amount of their meetings in public by June 2013 including conducting an Annual General Meeting in public from 2013.	The agenda and minutes of Board meetings are published on the hospital's web page. More recently, the Corporate Governance Manual, the Annual Financial Statement, the Statement of Internal Controls and the Annual Report have been posted on the website.	The publication of some Board papers is due to be considered by the Board later this year.
14. Boards should carry out an annual self-evaluation of the board, chairperson and board members, board committees, board operations and implement any improvements identified.	These elements form part of the Board's annual review processes. An externally facilitated review of the Board's effectiveness is currently underway.	
15. Boards should put in place arrangements to facilitate staff to raise concerns about the quality and safety of patient care, and to allow escalation of these concerns to the board for their consideration.	A comprehensive and well communicated risk escalation and incident management process has been adopted which staff can use to raise concerns. There are regular scheduled EMT 'walkarounds' where senior executives meet with frontline staff and listen to any quality and safety concerns they may have. There is also a well communicated "whistle blowing" (protected disclosure) process in place in case a staff member believes that there was an insufficient response from management/board to concerns raised. In addition, in May 2015 the Hospital repeated the staff patient safety culture survey which was rolled out by the HSE in 2013.	

HIQA Recommendation	Actions to Date	Future Planned Actions
16. Boards should have in place processes that allow them to consider information provided by external sources (including from patient advocates) in relation to the delivery of safe care to patients.	Each Board meeting opens with two "patient stories" – one compliment and one complaint. – in order to continually emphasise the need for a patient-focussed approach. Structures and processes have been introduced since 2013 (including the development of a Patient and Community Advisory Council) to ensure community stakeholders are involved in the development of the hospital. There are now regular meetings of the Patient and Community Advisory Council (PCAC) with five community members. An awareness day was held in May 2014. PCAC are leading out on specific improvements including the refurbishment of the atrium, hospital signage, tobacco free campus, suicide prevention and enhanced publicity for the group itself. The view of the patient is represented at Board meetings by the Director of Nursing.	It is planned to roll out a programme of patient surveys, commencing in 2015

HIQA Recommendation	Actions to Date	Future Planned Actions
17. The existing boards of healthcare organisations in receipt of State funds should review the effectiveness of the corporate and clinical governance and management arrangements in place in the organisation in order to satisfy themselves that they are consistent with these recommendations and develop and implement an action plan to meet them accordingly.	All four Board committees (Audit Committee, Remuneration and Terms of Service Committee, QSRM Committee and Governance Committee) play a role in assuring compliance with best practice regarding corporate and clinical governance and management arrangements.	
18. The chairperson must be accountable for ensuring that there are annually agreed objectives in place for the chief executive that accurately reflects the realm of their accountability, responsibility and authority.	Objectives are established annually by the Chairman in consultation with members of the Remuneration and Terms of service Committee.	
19. The chairperson must be accountable for ensuring that there is an effective process in place to support, develop and manage the performance of the chief executive. This process should incorporate the views of the Director of Hospital Care (or other designated individual) and other key stakeholders and should be undertaken by an appropriate committee of the board. Where there are issues of poor performance, the chief executive should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.	The performance of the Chief Executive is monitored by the Chairman. This includes evaluating performance during the probation period which is then presented for formal ratification by the Board. A process has been agreed by the Board for the Chairman to present the CEO evaluation to the Remuneration and Terms of Service Committee.	

HIQA Recommendation	Actions to Date	Future Planned Actions
20. A board should have access to the appropriate information in order to fulfil its role of effectively governing the delivery of high quality, safe and reliable healthcare. This should include the development of a quality and safety assurance framework with key performance indicators (KPIs) to assure patient safety, patients' experience, access and financial management. Every board should use these KPIs and other quality and safety information to assure itself about the quality and safety of care being provided and publish this information.	A Quality, Safety and Risk Management framework is in place which includes the presentation of monthly activity and performance data (including QSRM KPIs). The hospital Board now receive an integrated management report from the Executive Management Team every two months which includes a range of quality, operational and financial KPIs	

3.3 National HIQA recommendations under the remit of the Executive Management Team

Responsibility for implementing the following **19 national recommendations** has been assigned to the Executive Management Team (EMT) at Tallaght Hospital. This team comprises the CEO, four Clinical Directors and corporate function leads. Each of the recommendations has been assigned to a lead member of the Executive Management Team.

Of most significance was the immediate cessation following the HIQA announced site inspection in August 2011 of the use of the corridor adjacent to ED to accommodate admitted patients on trolleys. Tallaght Hospital has also demonstrated there is clear clinical accountability for patients at each stage of their journey through the hospital.

Tallaght Hospital is the first hospital in Ireland to fully roll out the early warning score system to detect and respond early to deteriorating patients. This tool has also been revised for use in Tallaght Hospital's Emergency Department. Early audit results indicate positive benefits to patient outcomes due to these initiatives.

The operational efficiencies achieved in 2012 are driven by the EMT, especially the Clinical Directors who have taken a leadership role in ensuring implementation of the national clinical programmes and other initiatives to drive greater efficiencies resulting in safer, more timely access and higher quality care.

HIQA Recommendation	Actions to Date	Future Planned Actions
1. Every hospital should cease the use of any inappropriate spaces (for example, a hospital corridor or parking area for trolleys) to accommodate patients receiving clinical care.	The use of the hospital's ED corridor ceased in August 2011. A patient flow project plan was then developed with a target to achieve zero trolleys with the support of the SDU. A standard operating procedure has been developed and implemented for boarded in-patients. Significant progress had been made but when attendances at ED peak there is still a requirement to place additional trolleys in the ward areas as part of the hospital escalation plan. Tallaght Hospital continues to work to reduce the use of inappropriate spaces to accommodate patients receiving clinical care. We have succeeded in providing more protection in our ED by reducing the 30 day moving average of Trolleys by 45%. An Acute Surgical Assessment Unit has also opened adjacent to ED as a pilot project under IHRP. There are also a number of projects underway targeted at improved ward and bed management.	There is ongoing work in this area. Specifically, an additional 12 beds are to come under the clinical governance of the Acute Medical Assessment (AMU) physicians It is also planned (subject to resource review) to expand the Acute Medical Assessment Unit and increase its hours of operation to cover Saturday and Sunday (extended day already in operation up until 9pm Monday-Friday). This improvement has been included as part of the Irish Hospital Redesign Programme which also includes the development of patient care pathways aimed at admission avoidance (e.g. PE, DVT and second seizures pathways) and early discharge (e.g. cellulitis pathway).
2. The National Early Warning Score (NEWS) should be implemented in all clinical areas providing inpatient care. An emergency department specific system of psychological monitoring and triggered responses comparable to the NEWS should be implemented.	The NEWS was rolled out to all the wards in 2012. A modified version is now in place in the ED for admitted patients. Ongoing audits of this initiative have demonstrated positive outcomes for patients.	The effectiveness and use of NEWS is constantly being evaluated by our EWS steering group with a view to improving and expanding its use throughout the hospital. It is planned to introduce the NEWS at ED triage as one of the IHRP projects

HIQA Recommendation	Actions to Date	Future Planned Actions
3. The working hours and availability of consultant on-call in other emergency service areas in acute hospitals, such as acute medical units, should also be reviewed and amended where necessary.	A review of specialities on-call has been completed in order to support operational efficiencies and ring fencing of beds. Approval for 4th AMU physician has been received which will facilitate better AMAU coverage.	There are ongoing reviews in this area. Plans to alleviate the onerous medical on-call rota and enhance the AMAU service are ongoing but are resource dependant. An Irish Hospital Redesign AMAU project is being put in place to optimise AMAU activity in short term.
4. All hospitals must have the necessary arrangements in place to ensure that there is a named consultant clinically responsible and accountable for a patient's care at all points in the patient journey and throughout their hospital stay	A Policy for Transition of Care when the Adult Emergency Department Considers a Patient likely to require admission was developed in November 2011 to ensure clarity of responsibility for patients in ED. There is a named responsible consultant in place for all in- patients and day-cases. The policy clearly indicates the position of the organisation on the transition of care when the Adult emergency Department considers that one of their patients will probably need to be admitted.	The Policy for Transition of Care is currently being updated with a target date for release in July.
5. All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that on-call clinical teams are available to see patients in the emergency department.	This is in place	

HIQA Recommendation	Actions to Date	Future Planned Actions
6. The total patient time spent in the emergency department should be less than six hours. This time should be measured from the time the patient arrives in the ED to the time of the departure from the Emergency Department. These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar case mix.	A commitment to implementing the under 6 hours standard is a high priority for the Board and executive. KPIs are reported to the Board and Executive Management Team monthly. Our current performance against the 6 hour Patient Experience Time target is 42%. In addition, the ED KPI's are submitted to the HSE and the SDU on a monthly basis and benchmarked against other hospitals with similar case mix. The metrics are available publicly on the Compstat website. Separate data has been made available for Adult and Paediatric Emergency Departments	To assist with internal improvement plans this data is to be made available separately for adult and paediatric EDs. We are introducing an Advanced Nurse Practitioner return clinic to improve PET (patient experience times) for non-admitted patients. In addition, the navigational hub improvements under IHRP is designed to improve PET for admitted patients
7. All hospitals should have the appropriate implementation and monitoring arrangement in place to ensure that early morning ward rounds are undertaken by senior clinical decision makers and that these form part of the explicit responsibilities of each consultant. Wherever possible, to facilitate multidisciplinary interaction and timely ward rounds, patients should be accommodated in centralised areas aligned to their admitting specialty.	Early morning rounds are carried out by many specialty teams. The average length of stay for each clinical team is continuously scrutinised with a view to agreeing and implementing plans for outliers to reduce their length of stay. A bed pooling (ring fenced) project and a project to increase weekly discharges and early discharges to the discharge lounge was implemented in 2014. A new protocol has been introduced where Clinical Registrars are encouraged to do earlier ward rounds with their consultants when the hospital has significant crowding with boarded patients in the ED.	There are ongoing reviews in this area. Further work is taking place to ensure all teams undergo early morning ward rounds led by senior clinical decision makers. .

HIQA Recommendation	Actions to Date	Future Planned Actions
8. All hospitals in Ireland should ensure that active patient discharge planning management is in place to include each patient having an individual discharge care plan with an estimated date of discharge from hospital.	This is in place. Electronic reporting to record the estimated date of discharge is audited on a two monthly basis. The Plan for Every Patient (PFEP) initiative was piloted on two wards. A project to increase weekly discharges and early discharges to the discharge lounge was implemented in 2014.	There is ongoing work in this area. Following partial implementation, the Visual Hospital initiative is now under review as part of the IHRP with a proposal to include some of the benefits of the initiative within the Navigational Hub project. An enhanced Transition Lounge is due to open at the end of April 2015. The navigational hub is also part of the IHRP.
9. All hospitals should consider, where appropriate, safe mechanisms are implementing nurse-led patient discharge processes with the appropriate supporting clinical governance arrangements.	Advanced Nurse Practitioners are engaged in nurse led discharge. Although staff nurses are actively involved in discharging patients there are no plans currently to expand their remit to include nurse led discharge.	
10. All hospitals should have effective arrangement in place to ensure that all patient waiting are periodically reviewed by a senior clinical decision maker to ensure that the clinical priority and urgency for each patient is managed and subject to regular review. Arrangements should include two-way communication with the patient and their general practitioner.	The hospital recognises the importance of clinical governance of our waiting lists and is working with senior clinicians to ensure the appropriate prioritisation of patients.	There is ongoing work in this area. The hospital is working with the HSE to address areas where the demand for services exceeds the capacity of the service.

HIQA Recommendation	Actions to Date	Future Planned Actions
11. Voice recognition and clinical alert software with a formalised process for critical alerts to GPs for abnormal patient imaging results must be put in place in all hospitals and monitored and evaluated on an ongoing basis.	Voice recognition software is now in use in many parts of the hospital. The need for critical alert software is recognised as being hugely important for the hospital. A successful pilot of such software has been implemented in Tallaght Hospital. A business case to implement this software locally and nationally has been sent to the HSE for approval.	The hospital is planning (subject to confirmed funding resource) to roll out critical alert software for both GPs and hospital clinicians. PeerView critical alert software has been integrated into NIMIS to improve our critical alert functionality
12. An analysis of activity, demand and utilisation should be undertaken in each hospital providing diagnostic services with a view to extending opening hours to better meet the needs of patients.	Laboratory and Radiology now operate on an 8am to 8pm core roster for specific modalities.	There is ongoing work in this area which will ultimately include a collective review of all diagnostic services within the Dublin Midlands Hospital Group.
13. The Chief Executive and the Executive Management Team should ensure that the implementation of the organisation's strategy, and the operational running of the business, is specifically and effectively addressed to the delivery of good quality and safe care within the available resources. The relationships with stakeholders, engagement with the public, organisational structure, delegated roles and responsibilities, governance fora, output and outcome measures and the business content of meetings should all reflect this purpose.	The Executive Management Team has been changed to reflect contemporary governance and management structures, including the development of the new Clinical Directorate structure. A new organisation structure was approved by the Board in September 2011 and its implementation has been overseen by the Remuneration and Terms of Service Committee. Hospital services are now measured and tracked to ensure they are in line with SLA, quality and SDU targets.	There is ongoing work in the hospital with respect to developing a corporate strategy with a particular focus, in the first instance on clinical services. In parallel, under the auspices of the of the Remuneration and Benefits Committee there has been a renewed focus by the executive management team with respect to developing an Organisational Development

HIQA Recommendation	Actions to Date	Future Planned Actions
14. The Chief Executive must be accountable for ensuring that there is an effective process in place to annually agree objectives that reflect the delegated accountabilities and responsibilities for executive directors, and all staff within the organisation in order to deliver high quality safe services to patients.	An Executive Management Team Framework is in place with annual objectives set for individual executives, in accordance with their job descriptions. These are subject to periodic review by the CEO throughout the year.	Consideration is now being given to how a similar performance framework could be rolled out to senior managers by the end of 2015.
15. The Chief Executive must ensure that there is an effective performance management and development system in place to support, develop and manage the performance of the executive directors and all staff within the organisation. Where there are issues of poor performance, the member of staff should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.	A Framework for Executive Performance has also been implemented in the Hospital for the Executive Management Team. HR support managers are in place to help with the performance management of staff.	Consideration is now being given to how a similar performance framework could be rolled out to senior managers by the end of 2015.
16. There should be a clear career progression for leaders and managers - both in non-clinical and clinical areas, to ensure that individuals receive the appropriate vocational training and development and human factor skills required for a senior management role.	Training for the Clinical Directorate Teams through RCPI was completed in September 2012. An organisational development plan is currently being developed in HR.	The Organisation Development Plan has been agreed by the Remuneration and Benefits Board Sub-committee. An independent review of its effectiveness has completed and identified a number of areas which should be progressed. A 3 year roll-out plan is being developed.

HIQA Recommendation	Actions to Date	Future Planned Actions
17. All Hospitals providing an emergency department service should undertake a periodic analysis of the types and profiles of patients who re-attend or leave without being seen and the underlying causes for re-attendance. Any potential improvements identified as a result should be implemented and evaluated. (Using this data, the HSE should set national key performance indicators (KPIs). These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar casemix).	The Hospital audits the rate of re-attendances. The numbers have dropped from 14% in the 2012 HIQA report to an average of 10%. This rate is monitored in Compstat on a monthly basis. A specific audit project on re-attendance has been completed. The patient flow programme prioritised this area for 2014. A review of Did Not Waits was carried out in 2014 and presented at our regular Emergency Medicine Programme meetings. The latest 2015 figures show Tallaght Hospital's medical readmission rates at 10%. This is in line with the national target.	Symphony (our ED Administration System) is being reconfigured to enable a presentation of updated DNW figures for the May Emergency Medicine Meeting A project is underway to review the profile of patients who re-attend and/or did not wait and the recommendations arising will be implemented in 2015.
18. All hospitals providing emergency care must continually manage and review the effectiveness of the patient-streaming, patient discharge arrangements, access to diagnostic investigations and fast-tracking systems in place.	A review of patient flow and streaming has already been completed as part of emergency care planning. An ED Clinical Operations Group has been established to review and improve activity data. A patent flow Governance Group is in place which focuses on many areas including access to diagnostics and fast-tracking systems in both scheduled and unscheduled care Discharge planners are in post who monitor and facilitate access to diagnostics.	System and process development is continuously ongoing in this area. A patient flow governance steering group has been established which will oversee both a Scheduled and Unscheduled care group. This structure supersedes the ED clinical operations and the patient flow governance groups.
19. All service providers must have clear accountability and performance management arrangements in place to achieve the delivery of high quality, safe and reliable healthcare.	The service level agreement is signed with HSE annually. Monthly performance meetings are held with the HSE through the Dublin Mid Leinster and the National Children's Hospital Governance group.	

3.4 HIQA recommendations under the remit of the Emergency Department, Tallaght Hospital

The HIQA inquiry into Tallaght Hospital was initiated by concerns for the quality, safety and governance of patients requiring acute admission to the hospital, primarily through the Emergency Department. Three of the national recommendations in the HIQA report relate to the Emergency Department.

The responsibility for implementing these recommendations at Tallaght Hospital has been assigned to the ED Team Lead Consultant and the Clinical Director of the Medical Directorate.

HIQA Recommendation	Actions to Date	Future Planned Actions
1. The working hours and availability of emergency medicine consultants and senior clinical decision makers should be reviewed and amended in line with the objectives and recommendations of the National Emergency Medicine Programme.	There are ongoing reviews of the working hours and availability of emergency medicine consultants and senior clinical decision makers completed by the Clinical Director for Medicine in line with the objectives and recommendations of the National Emergency Medicine Programme. A fourth consultant post was filled in July 2013 and an application for a fifth post is being prepared for submission to the HSE for approval. The nursing rosters were reviewed and recommendations implemented. A workforce review between the CD for Medicine and the ED consultants took place in 2014. The review concluded that four consultants with locum cover for leave would be sufficient.	Arising from the new ED development, rosters and work patterns will be reviewed in conjunction with the clinical care programmes and the IHRP to ensure the hospital leverages all the benefits of the new design and increased space in the ED.
2. The Manchester Triage System must be implemented, managed and periodically evaluated to ensure that it is being applied effectively in all hospitals.	The Manchester Triage System is in place in the ED and has been audited. Staff are having refresher training in this area and audits are taking place	There will be ongoing audits in order to improve compliance
3. All Hospitals in Ireland should monitor the implementation of the National Ambulance Patient Handover Time in line with the National Emergency Medicine Programme which requires 95% of patients being handed over from an ambulance crew to the emergency department staff in less than 20 minutes, and where this is not met, corrective action should be taken.	The EMP implementation team at Tallaght Hospital constantly review and measure the ambulance patient handover times.	There is ongoing improvement work in this area with continuous compliance reviews. Compliance rates are currently high (96%). We are currently developing software on the ED Symphony system to electronically capture ambulance handover time

3.5 HIQA Report recommendations not within the remit of Tallaght Hospital

There are 28 recommendations in the HIQA Report that are considered by Tallaght Hospital as falling outside the remit of the Hospital, in that responsibility for their implementation is a matter for the Department of Health, HSE or Special Delivery Unit (SDU). Confirmation of this has been received from Dr. Philip Crowley, HSE National Director of Quality and Patient Safety. These recommendations are listed below.

3.5 Local and National HIQA Recommendations under the remit of the Department of Health, HSE and SDU

Local Recommendations
The Charter should be replaced by the necessary legislative means to establish a fit- for- purpose Board.
The current AMNCH Interim Board[2] should be dissolved in the coming months, and, through a managed transition, a new substantive Board should be appointed.
National Recommendations
The involvement of general practitioners nationally in emergency departments, currently a reality in only a minority of hospitals, should be further enhanced and established on a formalised basis in partnership with primary care in all acute hospitals providing 24/7 care.
The Health Service Executive should review the current national position of the expanded roles within nursing and allied health professionals and implement a plan to roll out a more extensive programme of expanded practitioners within the appropriate clinical setting and with the necessary clinical governance arrangements in place nationally and locally.
National data pertaining to the quality, safety and timeliness for patients in all hospitals providing emergency department services should be monitored and published at local, regional and national levels.
The HSE, in conjunction with the Special Delivery Unit, should develop, monitor and publish a suite of composite quality, safety and access indicators measuring key points throughout the totality of unscheduled patient care.
The HSE nationally and Special Delivery Unit must ensure that there is a nationally integrated program-managed approach to the implementation of the Clinical Care Programme and patient admission and discharge strategies across the country which is effectively led, governed, managed and monitored at a national level. This process should provide active support to local service providers in order to ensure that that local implementation of each National Clinical Programme is managed as a single integrated and seamless improvement plan within a hospital and community and not as separate, fragmented and isolated initiatives that has the potential to result in competing priorities and resources.
The Health Service Executive and the Department of Health must as a priority review the current arrangements to provide patient access to multidisciplinary rehabilitation, community support and intermediate- and long-term care for patients requiring residential services. An integrated approach should be implemented, involving all health and social care professionals, with identified critical decision-making at key points and key performance indicators to ensure a timely and seamless transition for the admission to and discharge from the acute service.
Access to high demand, low capacity diagnostic imaging (for example, CT and MRI scans) should be reviewed at a regional and national level and the HSE nationally should develop, manage and coordinate access and waiting times for this type of imaging as a shared resource across all hospitals and

[2] The current Hospital Board is no longer an Interim Board.

primary care - particularly where there are long waiting times for patients.
Benchmarking and publication of outpatient department (OPD) appointment wait time across all hospitals at a national, regional, local and consultant level should be put in place.
The Department of Health should ensure that any required legislative amendments to the constitution of existing healthcare organisations in receipt of State funds take account of the recommendations.
The chairpersons of all hospital boards (in the first instance) in receipt of State funds should be line managed by a nationally designated post-holder for the purpose of holding the chairperson and the board accountable for the provision of well governed and effectively managed services and in relation to the appointment, performance and termination of the chief executive (this post holder may be, for example, the Director General of the new HSE structure, or equivalent).
The establishment of the boards of 'Hospital Groups/Networks' should be in accordance with the recommendations of this Report.
Boards should be of sufficient size [up to a maximum of 12] and expertise to effectively govern the organization. The board should be selected and appointed through an independent process established by the State and on the basis of having the necessary skills, experience and competencies required to fulfil the role effectively. The board should comprise non-executive directors and a chairperson and, in keeping with good governance, individuals with conflicts of interest, including employees of the hospital and those with other relevant conflicts of interest, should not be appointed to the board. The chief executive, and other designated executive officers [to include as a minimum the equivalent of the director of finance, medical/lead clinical director and director of nursing] should be formally in attendance at the board with combined shared corporate accountability for the effective governance and management of the hospital. *In advance of such an independent process being established, the members of boards with the necessary knowledge, skills, competencies and experience should be appointed by the Minister for Health.*
The Minister for Health should consider introducing remuneration of members of boards of organisations that are in receipt of State funds. A stronger performance management of board members should be introduced with consideration of the capitation of remuneration based on a defined percentage of the remuneration allocated as a core fee and the remainder based on the assessment of a board member by the chairperson within a performance criteria that includes attendance and contribution.

Existing boards of hospitals should consider replacing current and future vacant board director positions by using the independent process established by the State.
As part of the establishment of 'Hospital Groups/Networks' from the current State funded hospitals, competent high performing chief executives and executive directors [including director of finance, medical/lead clinical director and director of nursing] with clear delegated accountability should be appointed.
The appointment of the chief executive of a service provider in receipt of State funds should be overseen by a Board with the appropriate degree of involvement from the director of hospital care [or equivalent designated individual].
The chief executives of all hospitals [in the first instance] in receipt of State funds, should be line managed by the chairperson as their direct line manager and, in addition, by a nationally designated post-holder for the purpose of holding the chief executive accountable for the performance and delivery of the commissioned service [this may be, for example, the Director of Hospital Care of the new HSE structure, or equivalent].
The Department of Health should develop a national plan defining what tertiary and quaternary specialist services should be provided at which facility across the country, or contractually by other jurisdictions, based on informed factors including population need, forecasted activity and geographical distribution. This should be determined and implemented in advance of the universal health insurance system.
A comprehensive analysis, rationalisation and re-organisation of the distribution and provision of the types, number and operational times of [specific types of] hospital services in the Dublin area should be undertaken by the Department of Health and the HSE. The analysis should be based on current and future forecasted its population demographics, needs, demand, activity, resource requirements and service utilisation. The analysis should inform the development and implementation of a Dublin Regional Healthcare Services Plan in order to provide the optimum services required to best meet the needs of the population in the most effective and efficient way.
A population and policy-informed needs-based allocation for health services in Ireland, that reflects current and future demand and capacity, should be undertaken by the Department of Health. Such a model should recognize the need for research and innovation where appropriate and should inform the resource base for the modernising of service configuration.

The Department of Health should establish an Operating Framework for the health care and social care system that outlines the key elements for the effective operation of a high quality, safe and reliable health system which is optimally designed and held to account to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy. The core element of this framework should include: · clarity of the types of services provided in different types of facilities · the process by which specialist services are identified, resourced, delivered and monitored - the basis of resource allocation for defined services and service providers and a provision for variation of services · clear principles outlining the provider and the commissioner roles, responsibilities and relationship • an effective and deliverable contractual arrangement between the provider and the commissioner.
Structured quarterly and annual accountability reviews with the chairperson and chief executive of each healthcare provider in receipt of State funds [in the first instance hospital services] should be established through a defined mechanism involving, for example, the director of hospital services and the Chief Executive of the HSE, or the future Director General of the HSE.
The Department of Health should ensure that a suite of national key performance indicators for hospitals that measure core aspects of the business and include quality and safety, patient experience, access to services and financial management are developed. These should be collated, monitored and managed by hospitals in receipt of State funds and reported publicly.
The Department of Health should put in place a Special Measures Framework to actively address and act on circumstances in which substantial poor performance of the board and/or executive management of a hospital occur. This Framework should contain the provisions for intervention orders where the Minister for Health, or delegated individual or agency [for example the chief executive or future Director General of the HSE], believes that a hospital is not performing one or more of its function adequately or all, or that there are significant failings in the way the hospital is being run [including quality of care, patient safety, financial management issues], and is satisfied that it is appropriate for him/her to intervene. In such circumstances, an intervention order should be made.
A nationally deployed resource to support hospitals [and other healthcare organisations] that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management should be established. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required and providing tailored development.
The Minister for Health should, as a priority, establish an oversight committee in the Department of Health to ensure the implementation of the governance recommendations contained within this Report. The Committee should report to the Minister for Health and include international experts in the area of government and also patient representation.