Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

HIQA News

Issue 11 | June 2015

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Welcome

Welcome to the latest issue of HIQA News.

Since our last issue, the Authority has published the Portlaoise Hospital investigation report, whose findings show the importance of always putting patients first, acting when aware of risks, and learning from when things go wrong.

Our investigation was initiated following very negative experiences of a number of patients and their families attending the hospital. Their care fell well below the standard expected in a modern acute hospital.

Our report outlined a number of serious findings which have been accepted by the Minister for Health. We have made a number of important recommendations and look forward to their speedy implementation.

Following our investigation, we believe that it is vital that a national maternity strategy is urgently developed in order to ensure that the profile and models of maternity services meets the needs of women across the country.

Since we were established in 2007, HIQA has produced a substantial amount of recommendations and learning for public hospitals in Ireland through our various investigations, reviews and regulatory work.

These findings and recommendations are intended to be used by all healthcare services to inform and improve practice. We are now in the process of connecting these recommendations with overarching Standards contained in the *National Standards for Safer Better Healthcare*.

We will communicate this learning to support public hospitals to implement these National Standards. In addition, working with patient, clinical and professional organisations, we will develop draft standards for maternity services in Ireland for public consultation.

Meanwhile, our children's services, nursing home and disability centre inspection teams are visiting centres throughout Ireland to ensure that standards are being met. Our core objective is to promote, where necessary, the quality of life and the human rights of vulnerable people.

In other developments, our Health Technology Assessment Team (HTA) team is currently conducting three separate assessments to inform decision-making within the public health service. These related to chronic disease self-management, BCG vaccination programmes, and screening for atrial fibrillation, all closely linked to the published Ministerial priorities.

Our Health Information team has recently concluded a public consultation on Governance and Management Standards for the Health Identifiers Operator, a vital component of individual health identifiers. Once approved by our Board, the finalised standards will be published in due course.

In line with our business plan objective, we have also completed an international review of how other countries gather and use patient experience information. We will commence discussions for a national patient experience survey with the Department of Health and the Health Service Executive (HSE) in the coming weeks.

In other news, our Healthcare team has published new guidance on how we inspect hospitals for infection prevention and control. Healthcare Associated Infections are not an inevitable consequence of healthcare, and all patients have the right to high-quality healthcare in a safe environment.

We are also in the process of developing our Corporate Plan 2016-2019, and we will be consulting with our stakeholders and the public. The project will build upon our current Corporate Plan for 2013-2015, and we are very keen to hear your views on our future strategic direction.

Until the next time, very best wishes to all.

Phelim Quinn, Chief Executive

Pictured (centre) is Rachel Flynn, Acting Director of Health Information with HIQA, attending the recent IPPOSI event. See news item in this issue.

Post-Portlaoise, HIQA aims to help hospitals meet standards

Since we published the report of our investigation into Midland Regional Hospital, Portlaoise, we have begun work on linking various HIQA recommendations to overarching standards in the National Standards for Safer Better Healthcare to help public hospitals implement these standards.

Pictured at the publication of our Portlaoise Hospital investigation report were HIQA CEO Phelim Quinn; Margaret Murphy, patient advocate and member of the HIQA Investigation Team; speaking at podium, Martin Turner.

Since we published the report of our investigation into Midland Regional Hospital, Portlaoise, we have begun work on linking various HIQA recommendations to overarching standards in the National Standards for Safer Better Healthcare to help public hospitals implement these standards.

Over the past eight years, we have produced a large number of recommendations and learning for public hospitals in Ireland through our various investigations and other regulatory work. These findings and recommendations are intended to be used by all healthcare services to inform and improve practice.

A new report we are preparing will communicate some of this learning to support public hospitals in implementing the *National Standards for Safer Better Healthcare*. This is being done by connecting these recommendations with an overarching Standard in the *National Standards for Safer Better Healthcare*.

Our Chief Executive Phelim Quinn

These National Standards were mandated by the Minister for Health and published in 2012, and describe a vision for high-quality, safe healthcare. Our new document will connect our various recommendations with an overarching National Standard, to generate an awareness of how the Standards relate to real-world care delivery.

Meanwhile, in our Portlaoise Hospital report, we made eight recommendations to address risks and deficiencies locally and nationally. Among our recommendations is the creation of an independent patient advocacy service to ensure that patients' reported experiences are recorded, listened to and learned from, and reports published.

Our Chief Executive Phelim Quinn said, "This investigation was initiated as a result of the negative experiences of patients and their families in receipt of services in Portlaoise Hospital. Their experiences highlighted significant deficiencies in the delivery of person-centered care at the hospital. This care fell well below the standard expected in a modern acute hospital. We would particularly like to pay tribute to the patients and families who made contact with the Authority to outline their experience of care within Portlaoise."

Phelim Quinn emphasised that lessons learned should be shared between hospitals within the new hospital groups being developed around the country, between hospital groups and nationally throughout the wider healthcare system. He added that setting up the new hospital groups is a critical point in the modernisation of the Irish healthcare system.

He concluded: "We believe that clinical networks, such as that planned for Portlaoise Hospital, have the capacity to facilitate a common system of governance, the capacity for medical, midwifery and other staff to rotate between the two sites and more importantly, that the right patient is treated in the most appropriate clinical environment."

An Executive Summary and Recommendations of our report has also been published.

Oireachtas Committee discusses Portlaoise report

Our Chief Executive Phelim Quinn and our Director of Regulation Mary Dunnion attended the Oireachtas Joint Committee on Health and Children to discuss our Portlaoise Hospital investigation report, which attracted considerable feedback from members of the Oireachtas in attendance.

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At the Oireachtas meeting were Marty Whelan, Phelim Quinn, and

Phelim Quinn told the meeting: "I would like to acknowledge the courage and fortitude of the many patients and families who made contact with the Authority to outline their experience of care within Portlaoise Hospital. It should be acknowledged that their efforts, harnessed with the required actions of those charged with delivering services, should ensure a better experience for those availing of services at Portlaoise Hospital in the future."

Our investigation followed an RTÉ Investigations Unit Prime Time programme on the tragic deaths of newborn babies in Portlaoise Hospital and a later report by the Chief Medical Officer of the Department of Health. Committee members and other Oireachtas members who joined the meeting made a number of contributions.

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Mary Dunnion from HIQA. Image: Houses of the Oireachtas

Committee Chairperson Jerry Buttimer TD of Fine Gael said: "It is very clear in the report, from my own reading of it, that we did know who knew what was going on. If there is no accountability, we are just providing window-dressing and playing along with the system... It is important that we work collectively to resolve these issues to ensure patient safety is of paramount importance."

Billy Kelleher TD of Fianna Fáil told the meeting: "The report is damning. We cannot assess it any other way. It calls into question accountability and commitments in terms of basic governance and patient safety, not only in the context of maternity services but right across the spectrum of services provided at the hospital."

Addressing the meeting, Caoimhghín Ó Caoláin TD of Sinn Féin said: "The recommendations contained in the report are not made lightly. They are a professional assessment of deficiencies and needs within our health system, be it acute hospital settings or other settings across the health care sector."

Lucinda Creighton TD, Leader of Renua, expressed concern about the implementation of our recommendations, and added: "To echo the sentiments of previous speakers, one almost experiences a sense of déjà vu when reading the report because much of it repeats what we have heard previously."

Fine Gael TD Regina Doherty also told the meeting, "The first recommendation is probably the weightiest, notwithstanding all of the other deficiencies. The Authority talks about immediately setting up, between now and next May, an independent patient advocacy service."

Senator Colm Burke posed a number of questions, including about the process of appointing administrative staff, the number of maternity units that do not have a director of midwifery, requests for additional staffing and HSE oversight of the hospital. He also asked what mechanism was in place to ensure the HIQA recommendations would be implemented.

Independent TD Seamus Healy asked about the report drafting process, and the impact of budget reductions on patient safety. "The report is shocking and in reading it one feels all sorts of emotion, from sadness and disappointment to frustration and anger. Failure and dysfunction occurred at many levels," he told the meeting.

Deputy Mary Mitchell O'Connor asked about the safety of maternity services in Portlaoise Hospital and elsewhere, volumes of critical care activity in the intensive care unit of the hospital, and management oversight, and said, "where else does a mother have to go to risk her baby's health and to risk her own life before HIQA is called in?"

Deputy Sean Fleming of Fianna Fáil asked about the safety of services and physical infrastructure at the hospital, the memorandum of understanding between it and the Coombe Women and Infants Hospital in Dublin, management of medical negligence, the role of HIQA and Portlaoise Hospital, and management accountability. "Lessons should have been learned," he said.

Senator John Crown raised concern about medical staffing levels in Ireland and commented, "was there ever a country that found itself so much in the glare of the international spotlight for deficiencies in its obstetric services as this country… To think that we are still scratching our heads and trying to work out how to get the administration in place is very depressing."

Our Chief Executive Phelim Quinn responded to questions, and stressed the importance of having in place a proactive programme of monitoring services against standards. He said that HIQA believes such an approach not only obtains information from our healthcare system, but has a better chance of driving improvement, rather than reacting to crises.

Also responding to questions, our Director of Regulation Mary Dunnion said we see an urgent need for a maternity strategy to determine the type of maternity services being delivered in hospitals. She said the infrastructure and support structures of any hospital will dictate the type of service that should be there. "We see that as a critically important component," Mary Dunnion told the meeting.

New Corporate Plan being developed

Over the coming months, we will start developing our next corporate plan to provide a strategic direction for the Authority for the years 2016 to 2018.
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The Corporate Plan 2016 – 2018 will be a significant document, as it will direct our overall work, set out our vision and principles and what we will need to achieve them.

In developing the plan, we will be taking a range of factors into account including Government priorities, changes in the structures of health and social care provision, new or proposed legislation, the views of the public, service users and services.

The project will further build upon our current Corporate Plan for 2013 – 2015 and will aim to review and refresh our current strategy.

As part of this process, the Authority will in the autumn launch a public consultation on the draft corporate plan to seek your feedback on the future direction of the Authority. We would encourage you to contribute to our strategic direction.

In the meantime, if you have any questions about the process, please contact us at corporateplan@hiqa.ie.

Health information governance

Our public consultation on the Draft information governance and management standards for the health identifiers operator has been completed.
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Rachel Flynn, our Acting Director of Health Information

The project will lay the foundation for the introduction of individual health identifiers to the Irish healthcare system. Individual health identifiers are lifetime non-transferable numbers that uniquely identifies each person that has used, is using or may use a health or social care service in Ireland.

Commenting on the outcome of the public consultation, HIQA's Acting Director of Health Information Rachel Flynn said: "The Authority received over 70 responses from all across the health and social care sector. Quality feedback was received and the draft standards were well received.

"An advisory group meeting took place at the end of May and a finalised version of the standards is now being prepared. A statement of outcomes document in relation to the findings from the public consultation will be published in due course." The draft standards are available on www.hiqa.ie.

New guide to hygiene inspections in hospitals

We have published a revised guide to unannounced inspections undertaken to monitor compliance against the *National Standards for the Prevention and Control of Healthcare Associated Infections*.
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This guide focuses on the important elements of the 2015 monitoring programme and replaces the guide issued in March 2014.

In May 2009, HIQA produced the *National Standards for the Prevention and Control of Healthcare Associated Infections* to reduce risk and improve patient safety. The monitoring programme during 2015 will predominantly focus on the following three areas:

1. Hand hygiene compliance.
2. Cleanliness of the environment and equipment.
3. Effectiveness in implementation and monitoring of infection prevention care bundles.

HIQA's Director of Regulation, Mary Dunnion, said: "HIQA will continue to monitor the cleanliness of the hospital environment and the effectiveness of the measures to promote hand hygiene performance as before. In addition, the Authority's unannounced inspections will now monitor hospitals' effectiveness in implementing infection prevention care bundles."

Care bundles, which are a structured collection of evidence-based measures, can reduce the chances of infection occurring from a number of healthcare interventions when used reliably and consistently. Infection care bundles have been recommended in national guidelines to reduce the risk of infection that might occur in patients who have an intravenous line (drip line) or who have a urinary catheter in place to aid in their overall treatment.

Mary Dunnion added, "Healthcare Associated Infections are not an inevitable consequence of healthcare. Every patient has the right to high-quality healthcare in a

safe environment. Our inspections will assess each hospital to see that the recommendations in the national guidelines are met in order to reduce the risk of infection for patients. Each hospital is responsible for developing a quality improvement response to identify and address improvements where there is a non-compliance."

The findings of inspections will be made publicly available and published on the Authority's website, www.hiqa.ie.

Our Director of Regulation, Mary Dunnion

Child protection in direct provision

We have published a report on our inspection of the child protection and welfare services provided to children living in direct provision accommodation in four of the Child and Family Agency's service areas, namely Louth / Meath, Midlands, Sligo / Leitrim / West Cavan and Dublin North City.
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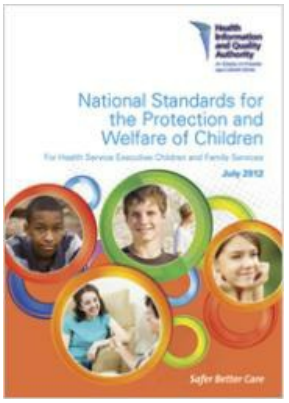

This is the first such HIQA inspection of child protection and welfare services in direct provision. Mary Dunnion, our Director of Regulation, said we have grave concerns about the high numbers of children living in direct provision who have been referred to the Child and Family Agency (Tusla).

Our analysis showed that approximately 14% of children living in direct provision were referred to the Agency in one year, which is a significantly higher referral rate than for the general child population of 1.6%.

There were approximately 1,600 children living in direct provision accommodation in Ireland, and of these children, there were 209 referrals of child protection and welfare concerns relating to 229 children between August 2013 and August 2014.

Of these referrals, 51% refer to child welfare issues while a further 49% refer to child protection concerns.

In some areas, there were significant delays in social work interventions.

Inspectors found that on occasion, the Reception and Integration Agency (RIA) moved families for safety reasons but gaps in communication between the providers and the Child and Family Agency at local level meant that this information was not always passed on. As a result, some social work interventions were delayed or did not happen and potentially placed children at risk.

To support these children and families, many staff provided excellent child-centred services, advocating for children and meeting their needs through timely and effective interventions, including seeking respite foster care for children, providing high-quality family support, and ensuring children were safe through home visits and by listening carefully to children about their lives.

HIQA has made four recommendations to the Child and Family Agency:

1. Develop an inter-cultural strategy to inform the provision of social services to ethnic minority children and families.
2. Complete an audit to ensure there are no children at risk of harm because of outstanding or incomplete assessments due to the movement of families between accommodation centres.
3. Ensure effective interagency and inter-professional cooperation with key stakeholders to ensure decisions consider the best interests of children.
4. Gather information on referrals to its services about children in direct provision accommodation to inform strategic planning.

HTA of BCG vaccination programmes

HIQA will in the near future begin a public consultation on a health technology assessment we are conducting of BCG vaccination programmes.
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HIQA's Director of Health Technology Assessment and our Acting Deputy CEO, Dr Máirín Ryan

Since the 1950s, the BCG (Bacille Calmette Guerin) vaccine has been routinely given as part of the routine childhood vaccination schedule in Ireland to reduce the risk of contracting tuberculosis (TB).

Policies on BCG vaccination differ both regionally within Ireland and internationally. In countries with a low incidence of TB, often only those at high risk are vaccinated. High-risk groups typically include healthcare workers and infants whose parents are from a country with high TB incidence.

A number of European countries and regions that previously had universal vaccination programmes (where all children are vaccinated), including the UK, France, Germany and Spain, have switched to programmes of selective vaccination for high-risk groups.

Ireland is considered a country with a low incidence of TB and therefore may be suitable for selective rather than universal vaccination. The use of selective vaccination reduces unnecessary vaccination and the numbers of adverse reactions.

However, a policy of selective vaccination will also result in some cases of TB that would have been prevented by universal vaccination. HIQA is now conducting a health technology assessment of BCG vaccination programmes.

Our Director of Health Technology Assessment and Acting Deputy CEO, Dr Máirín Ryan, said, "This assessment is aimed at building on previous work carried out by the National Centre for Pharmacoeconomics (NCPE) and the National Immunisation Advisory Committee (NIAC) to determine the potential impact of moving from universal to selective BCG vaccination in Ireland. The assessment will consider clinical, economic, ethical, societal and organisational issues. This HTA is due to be put out for public consultation in July 2015."

Residential services for people with disabilities

One of our biggest programmes of work is regulating designated centres for adults and children with a disability, and ensuring that residents' human rights are protected and promoted.
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This was a sector that had not previously been regulated when we assumed this function in November 2013.

We took responsibility for registering nearly 1,000 designated centres of varying sizes across the country. At the same time and in parallel, we continued to receive and respond to risk within centres.

Recently addressing the Annual Delegate Conference of the Irish Nurses and Midwives Organisation, our Chief Executive, Phelim Quinn, said: "We have seen and assessed excellent examples of progressive services that providers and the professional staff working within those services should be proud of."

He added that in the main, services that we have assessed as being significantly compliant with the relevant requirements have also embraced the vision set out in the Health Service Executive's 2011 report, *Moving on from Congregated Settings, a Strategy for Community Inclusion*.

At this stage we have now registered over 100 compliant services. However, he said our recent inspection findings across different provider organisations have highlighted a number of fundamental breaches of regulations and standards and in some instances in the human rights of individuals.

Phelim Quinn stated: "They most definitely run contrary to the UN convention on the rights of people with a disability. These examples exist in services provided in the public, voluntary and private sectors." Speaking in April at the National Disability Summit, Phelim said we need to ensure that we share the collective goal of making Ireland an exemplar nation in the promotion of rights and in its care and support of people with disabilities.

Children's team update

Throughout the past three years, our Children's Team has assumed responsibility for the regulation of an increasing number and diversity of children's social services.
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In the main, these services are provided by the Child and Family Agency (Tusla).

During 2015, we will engage in new approaches to the monitoring and oversight of some of these services based on the fact that they are provided by a single national provider with a single governance structure.

single governance structure.

This approach will use external expertise in the assessment of the agency's governance systems in the provision of child protection and welfare standards. This review will be in addition to our inspections of a range of other children's services.

Patients' healthcare experiences

While we aim to remain responsive to significant risk and service failure in the healthcare system, our planned programme for 2015 will be based on our desire to test how National Standards published in 2012 have translated into better care for patients and other service users in our healthcare system.
While we aim to remain responsive to significant risk and service failure in the healthcare system, our planned programme for 2015 will be based on our desire to test how National Standards published in 2012 have translated into better care for patients and other service users in our healthcare system.

The programme approach is aimed at sharing advance knowledge with providers of the sorts of assessments we wish to undertake in the coming years. Therefore, our programme for 2015 will include the development of new approaches in the assessment of patient experiences of healthcare services.

Commenting on the development, our Chief Executive Phelim Quinn, said: "In this venture we hope to work collaboratively with service providers and the Department of Health in the development and delivery of a comprehensive patient experience survey. We believe that a partnership approach in the area of patient experience surveys is vital and is supported by approaches taken internationally.

"In 2013, the Francis report into failings in the Mid Staffordshire Hospitals Trust in the UK highlighted the requirement for providers and regulators to attend to what service users were saying about the quality and safety of services. He highlighted that in addition to the complex range of data and information produced by healthcare systems, patients' experience was a key indicator of how services were performing in respect to quality and safety. More particularly, he said that patient experience data appeared to be a key indicator of when things were going wrong within services."

HIQA working on patient safety surveillance

We have completed an international review on patient safety surveillance systems, following a recommendation made by the Chief Medical Officer of the Department of Health in his report, HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).
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This entailed a review of important literature already published in relation to patient safety surveillance systems and an in-depth review of four regions and countries, namely British Columbia, Denmark, England and Scotland.

HIQA's Acting Director of Health Information Rachel Flynn said: "This provided us with a detailed understanding of the national, provincial and regional adverse event reporting systems in place that can be used for learning, improvement and triggering action where patient safety is at risk.

"As well as the reporting and learning systems themselves, we also particularly focused on the coordination of patient safety intelligence in the individual countries. This review will be published later this year."

Meanwhile, an 'as is' analysis by HIQA of the situation in Ireland in relation to patient safety surveillance is also currently underway. We will be convening an advisory group later in the year to help develop recommendations on the coordination of patient safety surveillance in Ireland.

New guidance for budget impact analysis

We are preparing to publish guidance on budget impact analysis of health technologies in Ireland.

We are preparing to publish guidance on budget impact analysis of health technologies in Ireland.

This will provide an overview of the principles and methods that are used in assessing health technologies, and will promote the production of high-quality assessments that are consistent and relevant to the needs of decision makers and key stakeholders in Ireland.

Our guidance on budget impact analysis of health technologies in Ireland document supports our previously published *Guidelines for the Budget Impact Analysis of Health Technologies in Ireland* by providing more detailed advice and examples to aid those conducting such an analysis.

It is designed to support clinical guideline developers, Health Service Executive (HSE) staff and anyone else carrying out health technology assessments conducted by, or on behalf of, HIQA, the National Centre for Pharmacoeconomics, the Department of Health and the HSE, including health technology suppliers preparing applications for reimbursement. This guidance document is due to be published shortly.

European Network of HTA Agencies

Pictured is a delegation from 22 countries of the European Network of HTA Agencies, of which HIQA is a member, who recently held a meeting in our Dublin office.

HIQA reviewing chronic disease self-management

Chronic diseases (ongoing conditions that can be controlled and managed but not cured) are reported as being the leading cause of mortality in the world, representing 60% of all deaths worldwide and 88% of all deaths in Ireland in 2014.
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Self-management-support interventions are any steps that help people to take control and manage portions of their chronic disease or diseases through education, training and support. They may be a worthwhile addition to best medical care.

Formal self-management support in Ireland is currently provided through a number of different avenues. However, at present there is uncertainty regarding the benefits of self-management-support interventions in the short and long term.

Our Health Technology Assessment (HTA) team is conducting an assessment of formal self-management support. The purpose of our HTA is firstly to evaluate the clinical and cost-effectiveness of chronic disease self-management-support interventions.

The assessment will also consider resource and costing implications as well as the wider implications that implementing chronic disease self-management-support interventions may have for patients, the general public, or the healthcare system.

Privacy and dignity of nursing home residents

We are continuing our work in the regulation of designated nursing homes with the objective of promoting quality of life for people living there, and protecting and promoting their privacy and dignity.
We are continuing our work in the regulation of designated nursing homes with the objective of promoting quality of life for people living there, and protecting and promoting their privacy and dignity.

This year, we have the challenging target of 250 centres to re-register, and are committed to ensuring that we continue to promote good practice in nursing homes through our thematic inspections.

Meanwhile, the physical environment in residential centres where older people live is a key component of high-quality care and demonstrates the regard that we have for the person being cared for.

When we started regulating nursing homes in 2009, it was recognised that the physical environment in a substantial amount of designated nursing homes did not afford the best possible levels of privacy and dignity to residents.

Providers were advised that compliance with the relevant requirements in this area would be needed by 1 July 2015. A regulatory notice issued to the sector in March 2013 reiterated this requirement and the July 2015 timeline.

John Farrelly, Head of Older Persons' Programme in HIQA, stated: "In 2014, we continued to focus on the adequacy of the physical environment for inspection and improvement. This approach will continue in 2015."

Registration applications will be renewed for the number of beds applied for if the premises are suitable and or if the Authority has accepted a costed, funded plan with a timeline that clearly sets out how compliance with physical environment requirements will be achieved.

Meanwhile, we recently received a presentation on multiculturalism from Age Action Ireland, which says care homes are at the forefront of a new multicultural and diverse Ireland, as many care home staff come from migrant or minority ethnic backgrounds.

John Farrelly said research has concluded that we need to begin opening up conversations to ensure that all staff are supported and recognised within the context of multiculturism and diversity.

HTA of screening for atrial fibrillation

We are finalising a health technology assessment (HTA) of a screening programme for atrial fibrillation, a condition in which a person's heart beats in an irregular rhythm (arrhythmia).
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Atrial fibrillation is the most common arrhythmia seen in general practice and is associated with a five-fold increase in the risk of stroke.

Strokes related to atrial fibrillation are also more severe, with twice the death rate of non-atrial-fibrillation-related strokes and greater functional deficiencies for those who do survive.

Irish data suggests that almost 40% of individuals with atrial fibrillation are unaware that they have an irregular heart rhythm.

The National Cardiovascular Health Policy 2010 – 2019 recommended that a screening programme for atrial fibrillation should be established for people aged 65 and over, following formal evaluation to ensure an effective means of implementation.

The Health Service Executive (HSE) National Clinical Programme for Stroke recently conducted a pilot project in a limited number of areas, to assess the feasibility of a national screening programme.

The Authority is undertaking a health technology assessment (HTA) of screening for atrial fibrillation to examine the clinical and cost-effectiveness of this intervention as well as the budget impact and resource implications of a national screening programme in Ireland. Our HTA is due to be completed in the near future.

2014 Annual Report and work plan for 2015

We have published our Annual Report for 2014, which provides an overview of the work undertaken by the Authority last year.
We have published our Annual Report for 2014, which provides an overview of the work undertaken by the Authority last year.

Meanwhile, a range of additional functions are to be assigned to HIQA under Government policy in the coming years.

Phelim Quinn, our Chief Executive, says this planned programme will be a challenging one for us as a relatively small organisation.

"I would also acknowledge that these changes have an impact on service providers and staff who will need to attend to the demands of regulation and or adherence to standards, guidelines and health technology assessments," he added.

Key among those changes will be:

- a revised Health Act, marking an extension of HIQA's monitoring powers into the acute private healthcare sector
- eventual transition to a programme of licensing for public and private healthcare services
- responsibility for the oversight of ionising radiation patient exposure regulations
- significant expansion in our programme of health technology assessment development

- developing standards to support the introduction of the individual health identifier
- developing standards in support of the eHealth Strategy and ePrescribing
- addressing recent recommendations on a national patient safety surveillance system.

Our planned programme of work in 2015 is aimed at meeting our core objectives of ensuring:

- Care is improved – we will enable sustainable improvements in safety and quality of health and social care services.
- People are safeguarded – we act to reduce the risks of harm and abuse to people using health and social care services.
- People are informed – we publicly report on safety, quality and effectiveness of health and social care services.
- Policy and service decisions are informed – we inform policy development and how services are delivered.

Update on HIQA-IHI programme review

We recently held two further graduation events for people working in health and social care services who have successfully completed the HIQA-Institute for Healthcare Improvement (IHI) Online Quality Improvement Programme.

We recently held two further graduation events for people working in health and social care services who have successfully completed the HIQA-Institute for Healthcare Improvement (IHI) Online Quality Improvement Programme.

In 2013, using a licensing arrangement with the US-based IHI, we introduced a structured learning programme in quality improvement science tools and methodologies.

Last year, a wide spectrum of health and social care staff took part, with 138 people across the health and social care sector completing the 2014 course.

Our Director of Safety and Quality Improvement Marie Kehoe-O'Sullivan, says: "At our recent graduation events in Dublin, 67 people working in hospitals, the disability sector, patient safety representatives and staff from HIQA all received their certificates."

Marie Kehoe O'Sullivan, HIQA's Director of Safety and Quality Improvement

International News Round Up

World Conference on Elder Abuse and WEEAD

Our Head of Older Person's programme John Farrelly spoke at the 10th World Conference on Elder Abuse and WEAAD (World Elder Abuse Awareness Day) 2015 Lead-up, which took place on 22 April in Dublin. The conference – organised by the International Network for the Prevention of Elder Abuse – considered advances in research into elder abuse, and associated practice and legislation. The event was opened by Kathleen Lynch, Minister of State at the Department of Health. The event also looked at raising awareness of protecting older people, a review of practice in countries across Europe and the role of regulation in safeguarding older persons.

IPPOSI Health Information Round Table meeting

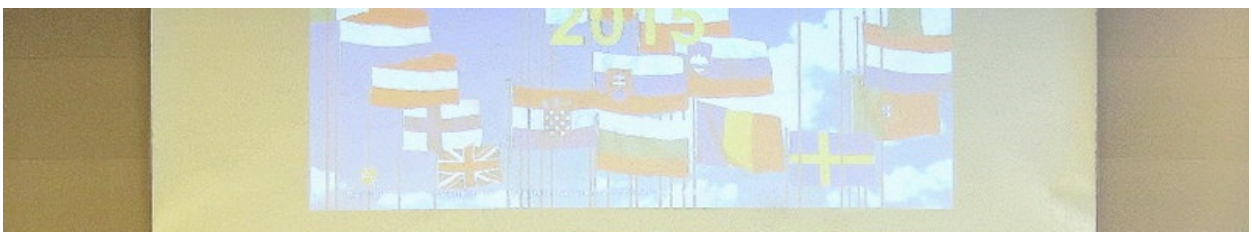
The Irish Platform for Patients' Organisations, Science and Industry's (IPPOSI) annual Health Information Round Table meeting with the Secretary General of the Department of Health in relation to health information took place in Dublin on 26 May.

There was a detailed discussion in relation to the legislative framework for health information, both the forthcoming Health Information Bill and also new forthcoming European legislation in relation to data protection.

Members of our Health Information team attended, including our Acting Director of Health Information Rachel Flynn, who spoke at the event about the importance of having a national strategic framework in place for national health and social care data collections.

Jim Breslin, Secretary General of the Department, gave a keynote presentation. Other presenters included Richard Corbridge, the Chief Information Officer of the Health Service Executive (HSE) and Garrett O'Neill from the Office of the Data Protection Commissioner.

EUnetHTA Plenary Assembly



HIQA's Director of HTA and our Acting Deputy CEO Dr Máirín Ryan (second from left) was among those who attended the recent EUnetHTA Plenary Assembly in Denmark

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