Attendees
Dr Michael McBride – Chief Medical Officer
Hugh McCaughey – CEO SEHSCT
Valerie Watts – CEO HSCB
Conrad Kirkwood, Safety Policy Branch, DoH
Gillian Hynes – DoH- (Secretariat)
Brian Godfrey, Safety Strategy Unit, DoH

Apologies
Sean Holland – OSS
Elaine Way – WHSCT
Lynne Charlton, PHA
Charlotte McArdle – Chief Nursing Officer
Ann McGlone – Willowbank Community
Mary Hinds, Director of Nursing and Allied Health Professionals
Jackie Johnston, DoH

Present for Agenda item 3
Anne Kilgallen, Deputy Chief Medical Officer, DoH

The Co-Chair of Q2020 Implementation Team and the Q2020 Project Manager were present for Agenda items 7 - 9
Dr Carolyn Harper, Director of Public Health/Medical Director - PHA
Grainne Cushley, Q2020 Project Manager – PHA

Present for Agenda items 9
Dr Rachel Doherty, BHSCT
Colin McMullan, BHSCT

1. Welcome and Introduction

1.1 Dr McBride welcomed all attendees and apologies were noted. He commented that this was the first meeting since January 2016 owing to postponements and a Q2020 workshop being held in May 2016.
2. Minutes of the Meeting on 21 January 2016

2.1 The minutes of the January 2016 meeting had previously been circulated to members for written approval in February 2016. No changes had been suggested, and members agreed the content by written procedure on 7 October 2016. They were provided at the meeting for information only.

3. Regional Improvement and Innovation System

3.1 Dr Anne Kilgallen gave an overview of the project to design a regional system for improvement and innovation. On 5 December 2017 she had been asked to lead two of the work streams which the Minister identified as immediate priorities within the transformation programme – the design of an “Improvement Institute” and the ongoing approach to identifying, scaling and spreading innovative HSC projects. These were so closely interrelated that it made sense to bring the work together as one.

3.2 This work was doubly important in the context of both Health and Wellbeing 2026: Delivering Together and the draft Programme for Government. These documents were unambiguously about improving outcomes for people living here and doing so with the involvement of staff and people to whom we offer services. None of this would happen consistently unless with intentional design.

3.3 In addition to this, both the Donaldson and Bengoa reports described the need for improvements in quality and safety in our system of care.

3.4 The timelines for this work were tight, with a draft of design concepts for improvement expected at end February and the first approach to scale and spread by end April.

3.5 Meetings were held in early January with an ‘Improvers Group’ who were a range of people currently involved in improvement and innovation work across the HSC; and later with ‘Critical friends’ who were individuals uniquely placed to advise on and guide this important work because of their knowledge of the current system and how improvement currently happens; and with whom current thinking can be tested.
3.6 From this starting point, a work programme had been proposed and a small Design Collaborative Group had been formed. This collaborative would take forward the work programme – for example, helping develop a narrative for the regional system and developing our understanding of what currently works well. Members of the collaborative facilitated a workshop on 21 February which was the first meeting of the community to co-design the regional system of improvement and innovation. The key message gained from the workshop is that there is already a huge amount of improvement work going on across the HSC, and that there is a real appetite for a regional approach. It was agreed that there is a gap in the regional system to enable and encourage improvement; particularly in relation to infrastructure, connecting people, IT capabilities etc.

3.7 Dr Kilgallen advised that on 8 March she presented an update to Transformation Implementation Group (TIG) on the system to date. The Chief Executives of the six Trusts all gave approval for the release of resources to allocate time to contribute to the system. These would be individuals already working on initiatives suitable to scale and spread. Trusts would shortly be asked to provide the Department with the nominees.

3.8 Valerie Watts asked whether the system/institute would be actual or virtual. Dr Kilgallen indicated that it would be difficult to work virtually as there were a number of digital barriers within the system; it was also important to build relationships. The intention was to gather a group to build a hub of people who could co-design the system and it was proposed to hold two hour monthly meetings for the next six months.

3.9 Hugh McCaughey added that there was a need to develop skills regionally and currently the science of spread was below par. He described the idea of ‘hotspots’ of improvement activity which could create networks and this would allow team disciplines to connect.

3.10 Valerie Watts enquired whether the scale and spread approach is currently discussed in management training programmes. Dr McBride described the work that NIMDTA do in relation to this and that this had led to its inclusion in NIPEC training.
3.11 Valerie Watts also enquired whether financial resources would be needed and Dr Kilgallen advised that there was a long standing bid for an improvement ‘hub’ particularly in relation to admin support and information storage and exchange. Hugh McCaughey added there was a lot of work going on that could be carried out without additional resource and gave some examples of these.

3.12 Dr McBride thanked Dr Kilgallen for her presentation and added that the challenge as an organisation was to find the direction and a way through.

4. **Action Points**

4.1 Dr McBride referred attendees to the 10 Action Points summarised in their papers. All 8 action points for the Department were complete. No attendees wished to make any further comments. The two action points attributed to the Implementation Team were addressed at paragraph 7.

5. **IHI Report**

5.1 Brian Godfrey referred to both papers provided for discussion and described how these papers showed linkages between Q2020 and the innovation and improvement scale and spread work. He added that the papers highlight that the message across the system is the same.

5.2 There was further discussion regarding the papers. In relation to sharing information regionally, Hugh McCaughey suggested a central repository for documents and resources. Brian Godfrey indicated that this is a technological issue discussed with the Design Collaborative and the challenge lies with IT restrictions.

5.3 In relation to the IHI report on Leadership, Dr McBride referred to the leadership work being undertaken as part of the Transformation agenda however it was not clear how papers such as this would be widely shared across the Department.

**Action Point 1 – Brian Godfrey** – To take forward the technology issue of document retention / repository through liaison with IT Assist.
Action Point 2 – Brian Godfrey – to liaise with Transformation Directorate to discuss arrangements for the sharing of papers.

Dr Carolyn Harper and Grainne Cushley joined the meeting at this point (11.10am)

6. Work programme priorities for 2017/18

6.1 This was moved for discussion to the end of the meeting (DN- we seem to be missing this. From recall the tasks tabled were discussed however it was considered that any new Q2020 tasks needed to be consider together with the outcome of Dr Kilgallen’s work in a requests to HSC Trusts for reports of improvement activity that could be suitable for scale and spread. It was agreed to await the outcome of this exercise before discussing the work priorities for 2017/2018.

Action Point 3 – Brian Godfrey to liaise with Dr Kilgallen in regard to Q2020 tasks interface with potential scale and spread innovation and improvement initiatives.

7. Implementation Team Action Points

7.1 Dr McBride welcomed Dr Carolyn Harper and Grainne Cushley, Q2020 Project Manager to the meeting. Grainne advised that both action points attributed to the Q2020 Project Manager had been actioned. This was agreed and noted.

8. Tasks Update

8.1 Grainne Cushley referred members to paper 5 which provided a full update on all current Q2020 project tasks and gave a verbal update on the latest position with the tasks. Over recent months there has been progress made in relation to the newly identified tasks for 2016/17 and incorporating the outcomes/outputs from existing tasks into practice. The majority of project tasks were on track for delivery against agreed timescales.

8.2 There was discussion around Task 2 – Annual Quality Reports (AQRs). This Task had now completed its fourth year and improvements had been made to the annual quality reports each year. AQR’s continued to be produced annually by Trusts; and a
minimum data set was reworked each year to reflect changes needed to streamline the reports. It was agreed to close this task and the Department would continue to write to Trust Chief Executives asking for the AQRs to be completed and published for World Quality Day in November each year.

**Action Point 4 – Q2020 Implementation Team** – To formally close Task 2 – Annual Quality Reports.

**9. Presentation on Supporting Staff through SAIs**

9.1 At 11.30 am a presentation on the Supporting Staff through SAIs task was delivered by Colin McMullan and Dr Rachel Doherty, Belfast Trust. This task focuses on the second victim aspect when staff involved in an unanticipated adverse event, medical error and/or patient related injury become victimised in the sense that the provider is traumatised by the event. The aim of the task is to agree models of support for health and social care staff following adverse events.

9.2 Dr Doherty gave an overview of progress to date. Following a review of the summary of evidence, a staff survey was developed and agreed and distributed in RBHSC Feb 201. Focus groups are planned for April 2017.

9.3 She then gave an overview of the initial analysis of the survey findings. 80 responses were received (14 online and 66 paper). Based on the total number surveyed of 710 Clinical and AHP staff this provides a response rate of 11.2%. The results showed that 36/80 (45%) staff had been involved in an adverse event and completed the entire survey; and 44/80 not involved in an adverse event, 5 of whom went on to complete some aspect of the survey. Demographics were available on 30 respondents.

9.4 Dr McBride asked for further information in relation to demographics and Dr Doherty provided a further analysis.

9.5 Colin McMullan provided an outline of Schwartz Rounds and how this approach was used in the project task. He described how Schwartz Rounds were not solely for the ‘second victim’ in adverse incidents but were a support for all staff, to share experiences and stop ‘second victims’ occurring.
9.6 Schwartz Rounds are a multidisciplinary forum for clinical and non-clinical staff to explore and reflect on some of the challenging psychosocial and emotional issues that arise when caring for patients. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

9.7 Dr McBride thanked Colin and Rachel for their presentation adding that for generations, staff and second victims have not been supported well and this was a very important area of work and he was pleased that it was being addressed.

10. **AOB**

10.1 There was discussion around the work priorities for 2017/18. It was agreed that there were tasks related to Q2020 that could be taken forward through the regional system for improvement and innovation.

**Action point 5 – Gillian Hynes** – Send Valerie Watts a copy of the previous and current ‘strategic look’ for project tasks.

**Please note the dates of future meetings**

22 September 2017 – 2PM – D2 Conference Room
## Summary of Action Points

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<thead>
<tr>
<th>Ref</th>
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