1. WELCOME, INTRODUCTIONS AND APOLOGIES

Mary Hinds, Director of Nursing and AHPs PHA welcomed everyone to the meeting, introductions were made and apologies noted.

2. MINUTES FROM PREVIOUS MEETING & MATTERS ARISING

Minutes from the previous meeting held on 12th October 2015 were approved by members as an accurate reflection of the meeting.

In relation to the action surrounding the standardisation of blood transfusion charts, Lynne Charlton advised members that, following discussions with Susan Atkinson, Chair of the Regional Blood Transfusion Group, the revised version of the BHSCT transfusion record will now include prescription of each planned transfusion. This means that the only variant from 3 other Trusts is lack of documentation of 3 sets of observations. In addition, Susan Atkinson had advised that a regionally
standardized transfusion record in NI is close to being finalised. Work is required to agree inclusion of other information in a regional record, for instance a tool to prompt staff to assess individual risk of transfusion associated circulatory overload (TACO), which is now the most common cause of death associated with transfusion. Consensus is also required on information given to patients about the risks and benefits of transfusion.

All other matters arising were dealt with through the main body of the agenda.

3. PRESENTATION ON TASK 13 ‘ESTABLISHING A PATIENT SAFETY CURRICULUM FOR HSCNI’.

Dr Keith Gardiner, Chief Executive, NIMDTA provided members with presentation on the progress made with the establishment of a patient safety curriculum for HSCNI which was a previously completed Quality 2020 task.

The group welcomed the presentation and the progress made to date. A suggestion was made to include AHP colleagues in further implementation and circulation.

4. UPDATE ON ONGOING TASK GROUPS

Mary Hinds referred members to the Q2020 Task update paper which had been tabled for discussion. Each task lead / nominated representative (on behalf of lead) was invited to provide a short update on progress made to date. The purpose of this exercise was to provide a regional platform for task leads to update on progress and share learning with other members. Mary advised that five new tasks for 2016 have been established following communication with the DOH and benefits realisation templates which outline the intended outcomes have been developed.

   1) Task 2 Quality Reports

Lynne Charlton provided an update on Task 2 (Annual Quality Reports) on behalf of Dr Cathy Jack, task Lead, BHSCT. The group were advised that a minimum dataset reflecting the 5 strategic goals of Q2020 had been developed by the Task Group and issued to HSC Trusts to ensure regional consistency in metrics used and reported within the Annual Quality Reports.. There has been ongoing work to establish a public / staff feedback survey which will be issued with Annual Quality reports in November 2016.

Conrad Kirkwood, Head of Safety and Quality Unit, DOH, whilst recognising the challenges, advised members that there is a requirement for reports to be presented to the public in an easy accessible style. All Annual Quality reports should be published on World Quality Day, 10th November 2016 following approval from DOH.
Action 1: Quality Report Minimum Dataset to be circulated to the group for information.

2. Supporting Staff involved in SAIs

Cathy Jack BHSCT and Alan Corry Finn WHSCT are the leads for this task. Since its initiation, a scoping exercise has been undertaken to identify examples of good practice in this area. A multi-disciplinary project team has been established, with membership including medical, nursing, social care and reflects individuals who have experience of being involved in incidents which have resulted in harm. A work plan and terms of reference will be agreed first meeting which is scheduled for 28th October 2016.

Members discussed the task and agreed that this was an important piece of work. The current membership of the group was considered and a few suggestions were made including:

- Representative / involvement from Prison Healthcare given the number of SAIs in this specific area.
- Involvement of junior medical staff in clinical incidents – Keith Gardiner, NIMDTA advised that a trainees support day was held last year in which several of the trainees shared their personal experience. Keith Gardiner will link with Adept Fellow already identified on the group.
- Involvement of regulatory bodies, such as GMC, NMC. Dr Richard Wright, Medical Director SHSCT advised that, whilst it may not be appropriate for representation to sit on the task group, consideration should be given to informing a representative of the work which will give insight into the staff perspective in these cases.

Action 2: Lynne Charlton to provide feedback regarding above points to Task leads.

3. Improving Patient Safety in NI through the use of Simulation-Based Education (SBE) and Human Factors
Mike Morrow, NIMDTA provided members with an overview of the task outlined above. He advised that an inter-professional task group, co-led by the Head of Clinical Education Centre has been established and an initial meeting has taken place. A scoping exercise has been completed and published by NIMDTA on the current state of medical SBE education and human factors training in NI and a mapping of the facilities available. A further scoping of Nursing and Midwifery training programmes and facilities is currently underway to complement existing scoping. Mike Morrow also advised that a network has been established and work is ongoing to broaden membership.

Members discussed the task and agreed that there had been a range of progress made to date which builds on the work led by Keith Gardiner on establishing a patient safety curriculum for HSCNI. Mike agreed to keep members updated on progress with the task.

4. Development of a HSC Standard for Safe Interventional Procedures based on the NatSSIPS to reduce the reoccurrence of the 3 main categories of Never Events

Lynne Charlton provided an update on the above task on behalf of Gavin Lavery, Task Lead, HSC Safety Forum. Lynne advised that work is underway to analyse the causative factors identified from existing SAIs which relate to wrong site surgery / wrong implant / prosthesis / retained foreign object post-procedure. Following this, the aim will be to engage with lead staff in this area to review the existing local standards to determine what revisions might be necessary to improve safety and harmonise with NatSSIPs.

Members reviewed the benefits realisation table which highlighted the intended outcomes and associated timescales. Mary Hinds asked members, if they had an interest in this area, to make contact with Gavin Lavery.

5. Strengthening Our Response to Adverse Incidents

An overview of the task was given on behalf of Angela McVeigh, and Margaret Marshall, task leads SHSCT. This task aims to review how adverse incidents are managed to identify how they can further develop and strengthen a culture of safety. Currently this is being led and piloted in the SHSCT with a view to learning and outcomes from the task informing regional future related work. To date a cultural questionnaire has been completed by 760 staff in SHSCT to capture current views on the adverse incident process. A project team has been established which has sought to include representation from patients and service users. A literature review
is currently underway to further inform project group this is due for completion by 21st October 2016.

Members discussed the task and reviewed the benefits realisation table. Members suggested, similar to the Learning from SAI task, that consideration should be given to ‘the second victim’ when reviewing this area of work. Lynne advised this was a consideration.

6. Pilot a model for the development of Always Events as a quality improvement task

Lynne advised that this is a newer task which has been identified by the DoH and welcomed the positive nature of the task. The task will be taken forward through the Patient and Client Experience Working group as a key area of work and the task leads will be Mary McElroy, Safety Quality and Patient Experience PHA, co-chaired by a nominated representative from Trust Nursing Governance team – name to be confirmed.

Mary Hinds thanked members for their contributions and updates. It was agreed that membership lists of each of the task groups would be sent to Grainne Cushley for dissemination to the group for information.

Action 3: Members to send list of membership of task group to Grainne Cushley

5. FEEDBACK FROM STEERING GROUP

Mary Hinds advised members that the recent Q2020 Steering Group meeting had been cancelled, however members were electronically circulated the Q2020 task leads update paper for approval. Conrad Kirkwood confirmed that the Steering Group approved the update paper which contained the benefits realisation templates for all new tasks.

Mary provided a short update on previous Q2020 tasks that are nearing completion / completed.

Developing Professional Leadership: Mary advised that the Attributes Framework e-learning training programme has been developed and implemented across HSC. A Commission Direction target for 10% of all HSC Workforce to be trained in level one by March 2017 has been identified and monitoring of this will commence in due course. In addition task group leads are currently exploring ways to take forward the next 3 levels of the attributes framework.
Minimum Mandatory Training: Mary advised that this task is complete in relation to social care, nursing and AHPs. We are currently awaiting final confirmation of actions. Patricia Higgins, NISCC advised that she is no longer the lead for this area of work.

Action 4: Grainne to send electronic version of update paper to members for information.

Action 5: Grainne to remove Patricia Higgins name as lead in minimum Mandatory Training update.

Action 6: Mary Hinds to discuss with Carolyn Harper and other re further direction of this task.

6. UPDATE FROM HSC SAFETY FORUM

Levette Lamb, HSC Safety Forum, provided members with a verbal update on progress relating to work of the Safety Forum on behalf of Gavin Lavery. Levette alluded to the range of collaboratives that are currently underway with HSC Trusts and provided an update on the progress with project ECHO.

Levette advised members that the Annual SAI Event is scheduled for 19th May 2017 and a call to Trusts for closed SAIs will be issued this month. In addition, the Safety Forum awards have been judged, there are a number of categories and the awards will be issued at the INNI Networking Event scheduled for 1st December 2016.

7. A.O.B

No other business was raised

8. Date and Time of Next Meeting

Action 7: Mary Hinds to discuss with Carolyn Harper re schedule of meetings for coming year.
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