CMO MEETING with MEDICAL DIRECTORS OF TRUSTS / DIRECTORS OF PUBLIC HEALTH 31 MARCH 2008 ROOM C3.18, CASTLE BUILDINGS, STORMONT

PRESENT		DEPARTMENT
Dr Peter Flanagan	NHSCT	Dr Michael McBride (Chairman)
Dr Anne Kilgallen	WHSCT	Dr Carolyn Harper Dr Maura Briscoe
Dr Paddy Loughran Dr Tony Stevens	SHSCT BHSCT	Dr Paddy Woods
Mr Charlie Martyn	SEHSCT	Ms Heather O'Neill (In attendance)
Dr David Stewart	RQIA	Dr Lorraine Doherty
Dr Anne Marie Telford	RHSCB	Dr Liz Reaney
Dr Janet Little	EHSSB	(Secretariat)
Dr John Watson	NHSSB	(Secretariat)
Dr Bill McConnell	WHSSB	
Dr Brid Farrell	SHSSB	
Dr Terry McMurray	NIMDTA	

1 Welcome and Apologies

Dr McBride welcomed all to the meeting and advised that apologies had been received from Professor Johnston, Dr Jenkins, Dr McManus, Dr Mitchell and Martin Bradley.

PART 1 - STRATEGIC ISSUE

2 Serious Adverse Incidents

Heather O'Neill gave a presentation on the key issues around a review of the serious adverse incident (SAI) reporting system. A copy of the presentation is attached for information. Discussion around the key issues of the review followed with particular emphasis being placed on the need to avoid duplication and find a balance between a reporting culture and a learning, no blame culture in order to encourage reporting and learning from SAIs. Concerns were expressed on the lack of clarity in the definition of SAI, in respect of roles and lines of responsibilities / accountability and the systems becoming an industry.

It was suggested that aligning complaints / claims and litigation and serious adverse incidents may be helpful. It was also suggested that the revised system should focus on learning, with a separate reporting line for incidents that need to be brought to DHSSPS / Board attention immediately. It was felt that the Regional Quality Improvement Authority (RQIA) should not routinely be copied into SAIs although it should be included in any subsequent sharing of learning. It was

suggested that the Northern Ireland Medical and Dental Training Agency (NIMDTA) should be copied in to SAIs relating to doctors in training so that individual training needs and curriculum revision can be considered. However, concerns were expressed that this may in effect mean all SAIs as medical staff in training are involved to some extent in most incidents due to the core services they provide. The membership of the SAI Group was discussed with suggestions made that representation from the training sector, RQIA and patient involvement should be considered. It was also felt that there should be a close relationship with Guidelines and Audit Implementation Networks (GAINs).

CMO indicated that the Department needs to ensure that a robust system is in place but there is a question as to where SAI should sit post RPA and whether the Department will need to be formally notified of SAIs in the future. CMO also indicated that the Undergraduate Curriculum Group should meet annually.

Action Point: CMO to arrange annual meeting of undergraduate curriculum group.

PART 2 - REACTIVE ISSUES

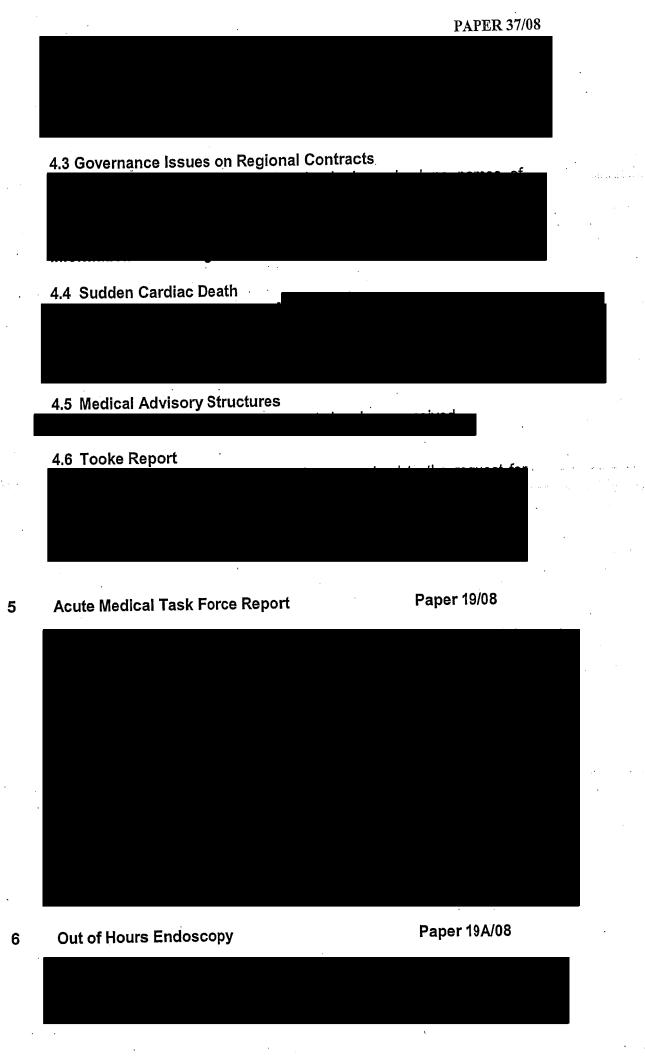
Minutes of Previous Meeting – 4 February 2008

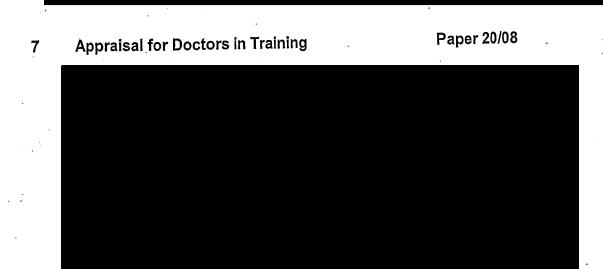
Matters Arising Paper 17/08 4.1 Hyperkalaemia Kit Pilot Exercise

4.2 Screening

Paper 18/08

Paper 16/08





8 Implications of NPSA Alert re Blood Transfusion Paper 21/08



9 Implementation of NPSA Hyponatraemia Guidance Paper 22/08

The Public Inquiry into hyponatraemia related deaths is likely to restart soon. Medical Directors were thanked for the return of hyponatraemia templates. Dr Briscoe advised that she will be responding to Trusts on the issues raised. Concerns including training issues were raised in relation to 13 -16 year olds. RQIA will be visiting 13 units by Friday. NIMDTA is looking at a hyponatraemia module.

Action Point: Medical Directors to provide update on audits at the next meeting

10 Healthcare Acquired Infections





11 National Confidential Enquiry into Patient Outcome and Death Paper 23/08



12 Safety and Quality Targets - PfA Paper 24/08

13 AOB

Next Meeting 19 May 2008

22 April 2008

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ITEM	ACTION	LEAD
Serious Adverse	Arrange annual meeting	CMO
Incidents	of undergraduate	
	curriculum group	
Hyperkalaemia Kit	Place on agenda for	Secretariat
	next meeting	
Screening	Issue letter to Trust	Dr Boyle
	Chief Executives	•
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	Reschedule update on	Secretariat
•	screening	1 1/2 A 4/2 TO
Governance Issues on	Feedback to	Dr Harper
Regional Contracts	Peter McLaughlin and	
	seek information re	
	learning from Scottish	
	experience	
Sudden Cardiac Death	Share output from	СМО
· · · · · · · · · · · · · · · · · · ·	workshop when	
	available	I Discotore
Out of Hours Endoscopy	Provide update at next	Medical Directors
	meeting	- 14 14
Appraisal for Doctors in	Provide update on step	Dr McMurray
Training	by step guide	I Diversions
Implementation of NPSA	Provide updates on	Medical Directors
Hyponatraemia	audits	
Guidelines		
Healthcare Acquired	Refine learning package	Dr Doherty
Infections	and target staff who	
	need to receive it	D. D.iaaaa
NCEPOD	Consider regional	Dr Briscoe
	workshop / relaunch	
		Members of Group
	Forward suggestions to	Mettiners of Group
	Dr Briscoe	

April 2008