DHSSPS / HSC MEDICAL LEADERS FORUM 30th April 2012

20.2

D2 LECTURE THEATRE, CASTLE BUILDINGS, STORMONT

PRESENT	•	DEPARTMENT
Dr Tony Stevens	Belfast HSC Trust	Dr Michael McBride
Dr John Simpson	Southern HSC Trust	Dr Paddy Woods
Dr Charlie Martyn	South Eastern HSC Trust	Dr Liz Mitchell
Dr Peter Flanagan	Northern HSC Trust	Dr Heather Livingston
Dr Tom Trinick	GAIN	Diane Taylor
Mr Keith Gardiner	NIMDTA	Dr Martin Donnelly
Prof Graham McGeown	QUB	
Prof Bernie Hannigan	HSC R&D	
Dr Jullian Johnston	Belfast HSC Trust	·
Dr Ciaran O'Gorman	South Eastern HSC Trust	
Dr Jillian Johnston	PHA	
David Bingham	BSO	

Welcome and Apologies

Dr Michael McBride welcomed everyone and opened the meeting.

Apologies were received from Dr Carolyn Harper, Dr Sloan Harper Dr Anne Kilgallen, Dr David McManus, Dr David Stewart, Dr Lourda Geoghegan, Angela McLernon

Professor Graham McGeown deputised for Professor Paddy Johnston

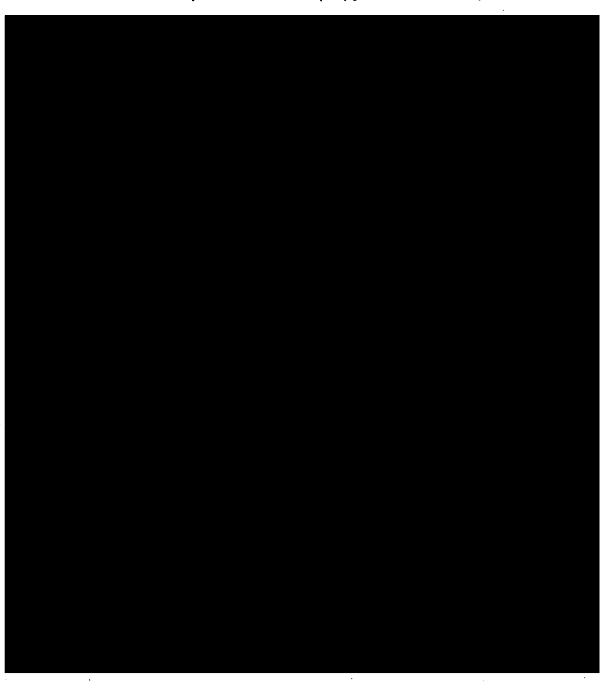
PART 1 - STRATEGIC ISSUES

1 Medical Leadership Programme Proposal





2 HSC Research & Development Evaluation (Copy Slides Attached)

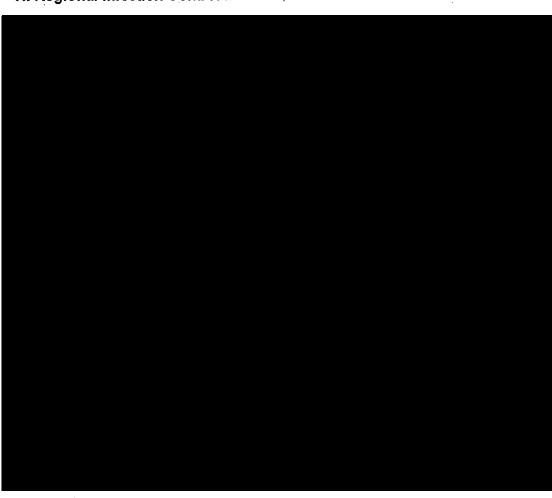


3 Healthcare Associated Infections - (Copy Slides Attached)

Changing Epidemiology



NI Regional Infection Control Manual



4 Trauma – Transfer of patients to Royal Victoria Hospital





5 Regional Fluid Balance Chart (Copy Slides Attached)

Dr Julian Johnston gave a presentation on the HSC Trust's Policy Collaborative (HSCTP Collab.) and in particular an update on the current position with the new Regional Fluid Prescription and Balance Charts - one for adults and one for children.

He also provided several PowerPoint training 'programmes' which covered the following areas

- 1. BHSCT Paediatric IV Fluid therapy & Hyponatraemia June 2011, which outlined the basics of paediatric fluid prescription and was based on the Paediatric Parenteral Fluid Therapy wall chart.
- 2. HSCTP Collab. Paediatric Fluid Prescription & Balance Chart Roll Out 2012, which instructed staff on the correct completion of the paediatric fluid prescription chart. It demonstrated the ability to correctly complete and calculate a fluid balance chart, and was used to explain correct and accurate completion to colleagues in the clinical environment. There is a similar package for adults.

He distributed the Policy Collaborative's terms of reference and a copy of its work plan to cooperate on selected policies with the aim of reducing time to plan, write and implement; basically by doing things once rather than 5 times.

He also advised that it is better to have one policy rather than 5 different ones. This is more efficient, safer for patients and cheaper but, once agreed, needs the 5 Trusts to stick to those agreed policy/standards/charts.

Fluid balance charts are the first result of this cooperation.

There would be benefits in reviewing the current work plan:

- 1. Medical (+ Nursing & Pharmacy) leaders need to agree that if Collaborative produces a single agreed item of work e.g. policy or chart, that all 5 Trusts will take them forward without making individual changes.
- 2. Needs improved engagement by medical, nursing and pharmacy clinicians. Need ownership of the main aim i.e. doing things 'once', by everybody and a willingness to strive towards producing a single piece of regional work, not just that which suits one's own Trust.
- 3. Role of Collaborative and its relationship to the Department, Board and each of the 5 Trusts needs discussed. At the moment the Collaborative 'sits' at Trust level good reasons for this. But, will it (should it?) evolve to sit 'higher' in the chain or have some other strategic guiding body?
- 4. Collaborative administration is resourced by BHSCT but formal resourcing is required in order to devote appropriate time.
- 5. Has no strict assurance framework; it sits outside the framework within each Trust.

There was discussion on

- how best the Trusts can facilitate and assist the development of the work of the collaborative going forward
- an organised mechanism for signing of work/output of the Collaborative
- role of GAIN
- endorsement of the Collaborative by HSCB and DHSSPSNI
- communication within Trusts and at a regional level HSCB and DHSSPSNI

The need to discuss the place of Collaborative within Quality 2020, Safety Forum was emphasised.

There was agreement that this was a great example of Trusts delivering from the bottom up and Dr Johnston was commended on what was an excellent product.

CMO thanked Dr Johnston for his presentation.

Action Point 3/ Apr 12: Secretariat to send a copy of slides and paper to the CNO and Dr Anne Kilgallen

Action Point 4/ Apr 12: Secretariat to invite Dr Johnston to a future meeting to provide update on the Collaborative.

6 Introduction



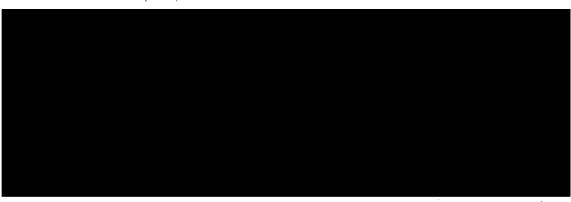
Pseudomonas



Guidance on Death, Stillbirth and Cremation Certification



Radiology – Review Phase 2



7 Minutes of Previous Meeting



8 Update on Outstanding Action Points



9 Any Other Business



Date of Next Meeting – 25th June 2012