South Eastern Health and Social Care Trust

SET Trust Board

Hyponatraemia Recommendations Implementation Update

20 March 2019

1.0 Introduction

This paper provides an update to the South Eastern Trust (SET) Board on work being undertaken, both locally and regionally, in relation to the recommendations of the Inquiry into Hyponatraemia Related Deaths (IHRD). The structure of the regional programme can be found in appendix 1 and the local Trust governance / reporting structure in appendix 2.

2.1 General Information

The Department of Health (DoH) have estimated that 80% of the recommendations will be implemented by summer 2020. The majority of recommendations require only operational changes, although some areas, such as a Duty of Candour Act, cannot be implemented until the return of an Executive and Assembly.

There will be accompanying assurance frameworks for each recommendation which may be audited by internal audit, although some areas may require independent assurance.

Independent Chairs were selected for those Workstreams which are considered to be at the forefront of public confidence and it has been emphasized that Non-Executive Directors (NEDs) are not representing individual Trusts, but are to provide challenge to the work being undertaken.

2.2 DoH communication and engagement with the Trust

As not every Trust is represented on every Workstream / group it is recognised there is a need for all Trusts to be kept up to date with the work of each group. The DoH has devised a communication strategy and will issue information from each Workstream to the Trusts to keep them updated. In addition, the Trust have assigned a member of staff as a central point of contact for IHRD related communications to support the Medical Director in the tracking and allocation of work, and dissemination of information.

A bi-monthly regional IHRD Trust oversight representatives meeting has been established to ensure the Oversight Committees continue to have a full picture and are clear on the expectations of the Department. This group will provide a forum for discussion of operational issues or problems within the Trusts, however it will have no decision making or advisory role. The group is chaired by Fergal Bradley, Implementation Programme Director, DoH. At the meeting, the Implementation Manager provides an update on the work so far and there is opportunity for attendees to raise any queries. Mr Martyn, SET Medical Director, and Linda Kelly, Assistant Director of Nursing, represent the Trust.

2.2 Trust IHRD Implementation Oversight Group

The Trust Implementation Oversight meets on a bi-monthly basis and provides reports to those groups in its governance structure, and other groups as required.

Each Trust has provided the DoH with an outline of that Trust's oversight arrangements. Most Trusts have a separate Paediatric Clinical group and are meeting on a monthly basis. Three of the Trusts have smaller groups than the SET (see appendix 3 for details of SET membership). The Chief Executive chairs the committee in two Trusts, the Medical Director in another two, and in one Trust the Medical Director co-chairs with the Director of Nursing.

The group continues to receive and discuss updates from members participating in the regional IHRD Workstreams / groups and consider matters escalated by the Management of Inpatient Children Working Group and other professional fora.

The group has engaged directly with the Chairs of the Workstreams, meeting in November 2018 with Dr John Simpson, Chair of Workstream 4 Paediatric Clinical Recommendations 10-30, and Dr Eddie Rooney & Lynn Charlton from Workstream 3, Chairs of Duty of Quality and the Clinical & Social Care Governance sub-group respectively, in December 2018.

3.0 IHRD Implementation Workstreams & Sub-Groups Update

Appendix 4 contains details of the IHRD Workstreams and their delegated tasks from the IHRD Report recommendations.

Workstream 1:	**Duty of Candour**
Chair:	**Quintin Oliver (Stratagem)**
Trust Representative:	**Helen Minford, Non-Executive Director**

The Workstream has commissioned research and is considering setting up a wider group to look at human rights issues. It has met twice since Christmas, including a joint workshop with the Being Open Subgroup.

Workstream 1:	**Being Open Sub Group**
Chair:	**Peter McBride (INSPIRE)**
Trust Representative:	**Bria Mongan, Director of Adult Services & Prison Healthcare**

No additional update.

Workstream 2: **Death Certification**
Chair: **David Best (DoH)**

Please see below sub-group updates.

Workstream 2: **Preparation for Inquests Sub Group**
Chair: **Vivien McConvey (VOYPIC)**
Trust Representatives: **Dr Ann Hamilton, Clinical Risk Director**

Each Trust has been asked to demonstrate their organisational structure for preparation for inquests, professional negligence claims and serious adverse incidents. There has been discussion in regard to inquest and litigation cases being held by the same staff in SET as the IHRD Report considers this a conflict of interest. The Trust has explained that inquest and litigation are rarely in progress at the same time and that the same person dealing with the case has advantages particularly by having knowledge of the particular case. Consideration therefore needs to be given as to how to reassure the public that there is no 'intent' to influence the case has been discussed.

The present position in all Trusts in relation to Recommendation 50 (R50 - The HSCB should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved) has been benchmarked and no Trust is in compliance at present. Questions as to the role of the Health & Social Care Board (HSCB) once it has this information, and whether it applies to all inquests, have been raised. It is thought regional guidance would be required. Following these discussions there has been a request for each Trust to return figures for how many inquests each had during the 2017 year to ascertain the volume of work recommendation 50 would apply to.

The group have had a workshop and a short presentation from the Directorate of Legal Services (DLS) on legal privilege. There is currently an appeal in the High Court after Coroner McCrisken stated privilege is absolute: either it is and you cannot be ordered to produce it, or it isn't and production can be ordered. In two cases the Coroner has asked for additional information about meetings/discussions including SAI reports, but so far these have not been shared pending a judicial decision.

Workstream 2: **Independent Medical Examiner Sub Group**
Chair: **Paul Finnegan (CRUSE)**

Members of the sub-group are looking closely at the arrangements for independent scrutiny in the rest of the UK and have visited Sheffield and Edinburgh to see how the systems work there.

Workstream 2:	**HSC Bereavement Network and Pathology Network Sub Group**
Chair:	**Sharon Wright (DoH)**
Trust Representative:	**Paul McCloskey, Bereavement Coordinator**

A baseline assessment of those recommendations which fall under the purview of the subgroup, specifically recommendations 44-47, 54 and 59-60, has previously been submitted. The group is currently looking at how recommendations are operationalised. Many are straightforward and could be used in current existing systems, but the group are looking at regionalising and standardising clinical summaries and post-mortems.

Workstream 3:	**Duty of Quality**
Chair:	**Dr Eddie Rooney**
Trust Representatives:	**Myra Weir, Director of Human Resources & Corporate Affairs & Jonathan Patton, Non-Executive Director**

Currently the group are progressing work on the development of the Assurance Framework for the implementation of the delegated recommendations, which includes the development of a clear operational statement of the objective, expectations of the objective, who the objective applies to and under what circumstances and who will be responsible for taking forward the objective.

The IHRD Involvement Strategy outlines the framework for the involvement of a wide range of stakeholders to work together to help, inform, shape and implement the recommendations, this is seen as key and the subgroup will discuss and consider the involvement plan at future meetings.

The group have identified clear linkages with the work of other work streams and will link as necessary to ensure collaboration and minimise duplicity.

Workstream 3:	**Arms' Length Body Effectiveness Sub Group**
Chair:	**Jim Moore (Translink)**
Trust Representative:	**Irene Low, Assistant Director Risk Management**

There have been lengthy discussions on the summary assurance framework and objectives exercise. Further work is required in this regard and Patricia Donnelly (HSC Leadership Centre) is writing this up. Irene Low has been asked to work with David Nicholl and June Champion in respect of standardising storage of Board Papers.

Workstream 3: **RQIA Remit Sub Group**
Chair: **Linda Greenless (DoH)**

The group has begun the process of a wider review of the role of RQIA.

Workstream 4: **Paediatric Clinical Recommendations 10-30**
Chair: **Dr John Simpson**
Trust Representatives: **Dr Bernadette O'Connor, Associate Clinical Director for Paediatrics, and Teresa Mungur, Clinical Manager Paediatrics and Neonatology**

The group continues to meet on a monthly basis.

Dr Simpson and Dr Joanne McClean (PHA) met with SET clinical staff to explore the implementation of recommendations 10 & 12 in December 2018.

R10- Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.

R12- Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.

Dr Simpson was keen to meet with adult teams particularly surgeons who have significant input into patients in age group 14/15. Dr Simpson clarified that this is to ensure and discuss the lines of communications have between paediatricians and adult teams in relation to maintaining support from each team as required, recognition and communication of the deteriorating child and safety measures in place to get paediatric support when needed. The meeting also discussed R13: Foundation doctors should not be employed in children's wards. It is likely this recommendation will be challenged.

The Trust has submitted a response to the in regard to how it develops, manages, changes and preserves/retains rotas; what system, procedure or off the shelf package is in use and whether it plans to adopt something new in the near future.

It is expected the groups work will be mostly completed by the end of 2019. Following this a new regional group, the Paediatric Network, with support from the Public Health Agency (PHA), will coordinate further quality improvement work.

Workstream 5: **SAI Recommendations**
Chair: **Conrad Kirkwood (DoH)**
Trust Representative: **Brendan Mullen, Associate Clinical Risk Director**

The most critical piece of work underway is the "Statement of patient rights of what to expect when they are involved in an SAI". Members have discussed patient involvement in the SAI process and noted that patients may not get the outcome they expect given it is a learning, not disciplinary, process. The Workstream expects to engage with a wide range of stakeholders over the next two months to finalise the guidelines including an online survey, which is now available to complete.

Work has also been undertaken to provide a regional breakdown of the number of SAI related deaths for 2017/18 by –

- Level 2
- Level 3
- Child
- Adult

A further Task and Finish Group is to be established to review R82 & 83:

R82 - Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.

R83 - Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.

Workstream 6: **Training;**
Chair: **Keith Gardner (NIMDTA)**

The group is considering those elements which need to be delivered as part of the education of the future and emerging workforce and will provide advice to Workstreams on developing training and education material. It is also currently undertaking work to map out existing responsibility for the education and training of the health and social care workforce.

Trusts have been asked to complete a baseline assessment in regard to recommendations assigned to this Workstream with submissions due by 22 March 2019.

Workstream 7: **User Experience and Advocacy**
Chair: **Rodney Morton (DoH)**
Trust Representative: **Joan O'Hagan, Non Executive Director**

This Workstream includes a number of service users, carers and people from the third sector. It has commissioned research to find out if there are better ways of providing advocacy to help service users and carers which can be learned from elsewhere.

Workstream 8: **Workforce and professional regulation;**
Chair: **Andrew Dawson (DoH)**

The recommendations assigned to this group are closely linked to those being considered by other Workstreams. The group will meet during 2019 to assess other group's progress with implementing linked recommendations and to consider the timeframe for implementing this group's seven recommendations.

Workstream 9: **Assurance**
Chair: **Olive Macleod (RQIA)**

This group is responsible for advising the Department through the management group whether or not there is evidence that each recommendation has been implemented and sustained in practice.

It has developed a framework with four areas that could assure the successful implementation of the recommendations. The assurance framework is based on contributions from the eight other Workstreams to show that there is clear evidence that actions are taken to cover each of the recommendations, and that they can be properly monitored into the future.

The bulk of its work will come as the proposed actions are passed over to it, It expects each Workstream in the programme to take an agreed approach to identify the objectives of each recommendation; the internal processes needed for implementation (training and education for example); the evidence needed to show that the recommendation has been implemented and to identify and mitigate any risks to implementation. Individual Workstreams are now working through this process, initially setting out objectives.

4.0 Management of Inpatient Children Working Group Update

This group now meets on a quarterly basis. Low sodium results continue to be monitored and investigated too the appropriateness of the prescription, any concerns discussed and acted upon.

A daily report from the Trust Information Team highlighting any child admitted to an adult ward is reported to appropriate staff. There are discussions in regard to a potential eDAMS solution for tracking children in adult wards through a combination of reporting, highlighting and alerts.

An Age Appropriate Care Nurse to provide support on the wards has recently been appointed. Development on a policy to support the delivery of Age Appropriate Care has also been initiated by the Clinical Manager for WACH. A pharmacist in acute paediatrics and a paediatric diabetic nurse have also been appointed to provide additional support.

For the time period July 2018 to January 2019 there have been 10 admissions to cohort wards and two admissions not to cohort wards. Patient time spent on cohort wards has reduced with the Age Appropriate Care Nurse now in post. The group has expressed concerns that staff cannot keep the required skills up to date if admissions continue to be low, although there has been no winter rise in admissions so far. Following escalation of the matter to the Oversight Group, that group agreed that incremental reduction in cohort ward numbers would be an appropriate option and it would be sensible to begin that process. The Oversight Group have requested that this be taken to the Management of Inpatient Children group with the Oversight group to endorse the final decision and plan, including a contingency plan for winter when more children may need admitted to cohort wards.

From January 2019 individual monthly subscriptions or an organisational subscription is now required to access the e-learning modules on the British Medical Journal (BMJ) website. This will have a regional impact as the modules form part of the Hyponatraemia competency framework. This development has been raised with the PHA who was, at that time, unaware. The PHA has agreed to cover organisational costs until end of March 2020 and will be exploring a future solution. The Trust will write to the PHA in regard to this future commitment.

5.0 Departmental HSC Liaison Group Update

The Departmental HSC Liaison Group continues to meet on a quarterly basis. The SET is represented by Mr Martyn, Nicki Patterson, Seamus McGoran and Dr Bernadette O'Connor.

6.0 Non-Executives Liaison Group

This group has not been convened. The Trust has contacted the Conrad Kirkwood (IHRD Implementation Manager, DoH) to request an update.

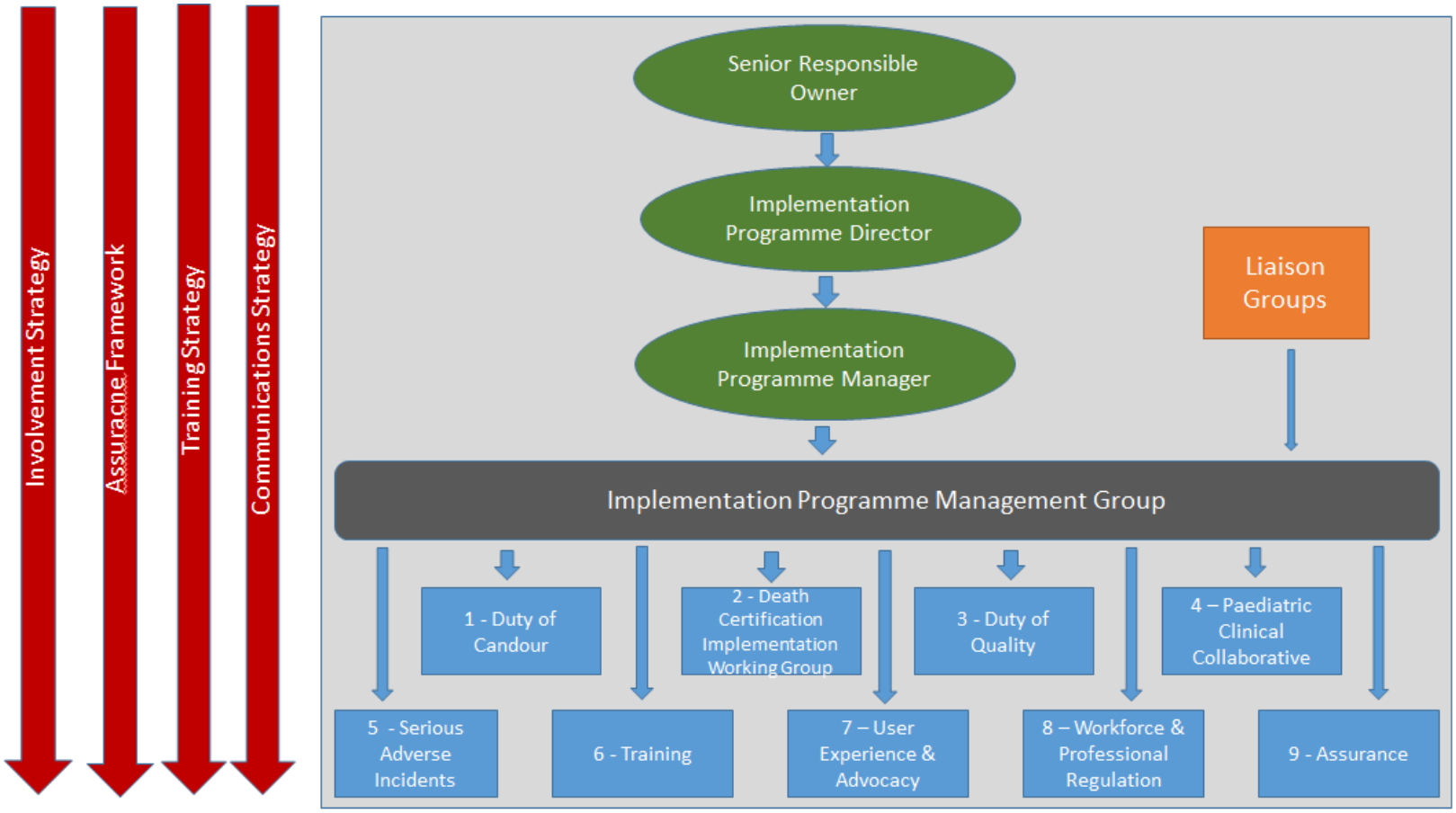
7.0 Additional Information

A regional IHRD stocktake event is to take place Tuesday 28 May 2019 at Mossley Mill. The Trust has been asked to nominate two Oversight Group members to attend. Other SET Oversight Group members participating in regional IHRD groups / Workstreams will be invited to the event separately via those forums.

South Eastern Health and Social Care Trust

Appendix 1

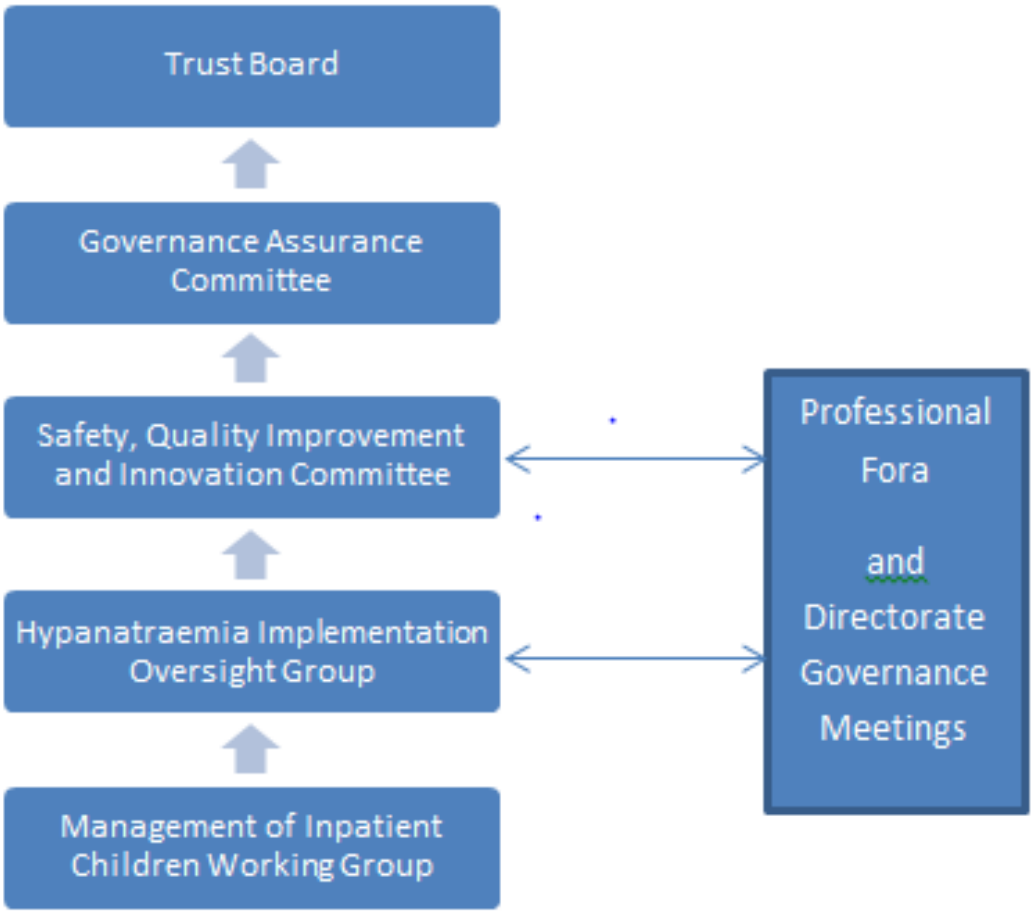
IHRD Programme Structure



South Eastern Health and Social Care Trust

Appendix 2

SET IHRD Implementation Oversight Group Governance Framework



SET IHRD Implementation Oversight Group Membership

Mr Charlie Martyn (Chair)	**Medical Director**
Dr David Hill (Deputy Chair)	**Associate Medical Director**
Jonathan Patton	**Non-Executive Director**
Helen Minford	**Non-Executive Director**
Joan O'Hagan	**Non-Executive Director**
Seamus McGoran	**Director of Hospital Services**
Nicki Patterson	**Director of Nursing, Older People and Primary Care**
Myra Weir	**Director of Human Resources & Corporate Affairs**
Bria Mongan	**Director of Adult Services & Prison Healthcare**
Dr Ann Hamilton	**Clinical Risk Director**
Brendan Mullen	**Associate Risk Director**
Dr Tim Harding	**Clinical Director Medicine**
Dr Bob Darling	**Clinical Director Surgery**
Dr Bernadette O'Connor	**Associate Clinical Director Paeds**
Mr Glen Marshall	**Associate Clinical Director Surgery**
Dr Roland McKane	**Associate Clinical Director Medicine**
Prof Thomas Trinick	**Clinical Director Labs**
Mr Alister McIlwee	**Consultant Emergency Medicine**
Linda Kelly	**Assistant Director Nursing**
Maggie Parks	**Assistant Director Surgery**
Colin Spratt	**Assistant Director Medicine**
David Robinson	**Assistant Director WACH**
Irene Low	**Assistant Director Risk Management**
Jill Macintyre	**Head of Pharmacy & Medicines Management**
Liz Campbell	**Safe & Effective Care Manager**
Teresa Mungur	**Clinical Manager Paediatrics and Neonatology**
Dr Anne-Marie McClelland	**ADEPT Fellow, Paediatrics**
Paul McCloskey	**Bereavement Coordinator**
Scott Hyvart	**RM&MRs Implementation Facilitator**
Joanne McKissick	**Patient Client Council Representative**

South Eastern Health and Social Care Trust

Appendix 4

IHRD Workstreams and Delegated tasks from IHRD Report Recommendations

Workstream Number	Workstream Name	Actions	Recommendations for implementation Category and Number
1	Duty of Candour	11 Actions from 5 Recommendations	Candour: 1 (i), 1 (ii), 1 (iii), 1 (iv), 1 (v), 1 (vi), 1 (vii), 2,3,4,6,
2	Death Certification Implementation Working Group	22 Actions from 18 Recommendations	SAI Investigation: 36, SAI Death: 43, 44, 45, 46, 47 (i), 47 (ii), 47 (iii), 47 (iv), 47 (v), 48, 49, 50, 51, 52, 53, 54, Training: 59,60, Department: 87, Culture and Litigation: 95, 96
3	Duty of Quality	28 Actions from 23 Recommendations	Candour: 8 Leadership: 9, SAI Investigation: 34, 40, 41, Training: 55, 56, 67, 68, Trust Governance: 69 (i), 69 (ii), 69 (iii), 70, 71, 72, 76, 77, 78, 79, 80, 81, 84, Department: 86 (i), 86 (ii), 86 (ii), 90 (i), 90 (ii), 92
4	Paediatric – Clinical	21 Actions from 21 Recommendations	Paediatric – Clinical: 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30

5	Serious Adverse Incidents	18 Actions from 10 Recommendations	SAI Reporting: 31,33 SAI Investigation 37 (i), 37 (ii), 37 (iii), 37 (v), 37 (vi), 37 (vii), 37 (viii), 37 (ix), 37 (x), 38, 39, 42, Training: 66 Trust Governance: 82, 83, Department: 91,
6	Training	6 Actions from 6 Recommendations	Training: 57, 58, 61, 62, 64, 65,
7	User Experience and Advocacy	3 Actions from 3 Recommendations	SAI Investigation: 37 (iv), Training: 63, Department: 89
8	Workforce and Professional Regulation	7 Actions from 7 Recommendations	Candour: 5, 7, SAI Reporting: 32, SAI Investigation: 35, Trust Governance: 73, 74, 75,
9	Assurance	1 Actions from 1 Recommendations	Department: 93