South Eastern Health and Social Care Trust

SET Trust Board

Update on the Implementation of Hyponatraemia Recommendations

Friday 31 January 2020

1.0 Introduction

This paper provides an update to the SET Trust Board on work being undertaken, both locally and regionally, in relation to the recommendations of the Inquiry into Hyponatraemia Related Deaths (IHRD). The structures of the regional and local programmes can be found in appendices 1 and 2. The latest DoH update published on 16 December 2019 can be found here.

2.0 Regional Update

2.1 Implementation of Recommendations

Prior to publishing each recommendation, implementation letters will be required to go the through the Assurance Workstream. The last Trust Board update report indicated that by October 2019 there would be a steady stream of circulars being issued detailing how individual recommendations should be implemented. It is now expected that the first recommendation circulars will be issued by the end of January 2020.

It is also anticipated that a set day will be established for issuing new letters each month. Furthermore, that as Recommendations are completed some Workstream groups and sub-groups will stand down or be transformed into smaller groups with meeting frequency decreasing also.

2.2 Trust IHRD Implementation Oversight Group

The Trust Implementation Oversight Group continues to meet on a bi-monthly basis and provide reports to groups in its governance structure, and other groups as required. 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.

Since the last Trust Board update report the group has received Mr Conrad Kirkwood, Deputy IHRD Programme Manager, as part of the group's continuing engagement with the Programme.

Members of the group, and other Trust staff, have also continued to participate in IHRD Programme events including the 'Involving Children, Young People and Parents in HSC Settings' event held in October 2019, and the workshop for the draft HSC board member handbook in January 2020. An invitation to be involved in two workshops raising awareness of the recommendations around Serious Adverse Incidents, to be held in January and February 2020, has also been issued to all Trust staff.

2.3 SET Stocktake Event

Following the regional stocktake event in May 2019, the IHRD Programme suggested that HSC Trusts consider running similar in-house events. The DoH

IHRD team would facilitate invites to relevant Workstream chairs that Trusts would wish to attend their planned events. The Oversight Group has taken some initial deliberations as what such an event should look like, and to ensure meaningful engagement a scoping exercise to gauge what matters to staff is underway.

3.0 Supporting Age Appropriate Care Update

3.1 Supporting Age Appropriate Care

Work is continuing to deliver the regional directive on the delivery of age appropriate care (children aged of up to 16th birthday should normally be admitted to paediatric wards) including:

- Implementing policies and procedures to ensure that children and young people up to their birthday receive age appropriate care;
- That arrangements are in place to ensure paediatric input to the care of children and young people up to 16th birthday who are admitted to non-paediatric settings when this is required;
- Ensuring that transition arrangements are in place for the transition of patients into adult services;
- Ensuring that paediatric staff are trained and supported by adult colleagues where necessary to support their management of children and young people up to their 16th birthday and beyond where this is clinically appropriate

To support the delivery of age appropriate care the Trust has employed an Age Appropriate Care Nurse and Paediatric Diabetic Nurse Specialist, both of which have been funded through Transformation monies. However, this funding stream is due to end 31 March 2020. It is therefore essential that further funding is secured to ensure sustainability and achieve full implementation of the age appropriate care directive within the organisation.

The Management of Inpatient Children Working Group continues to meet on a quarterly basis. Low sodium results continue to be monitored, with no concerns identified so far; and work to improve the associated reporting processes by looking at real time reporting is continuing. IV fluids also continue to be monitored with feedback issued and discussed at Audit meetings. An improvement group is also being established to address issues, although the number of incidents appears to be decreasing.

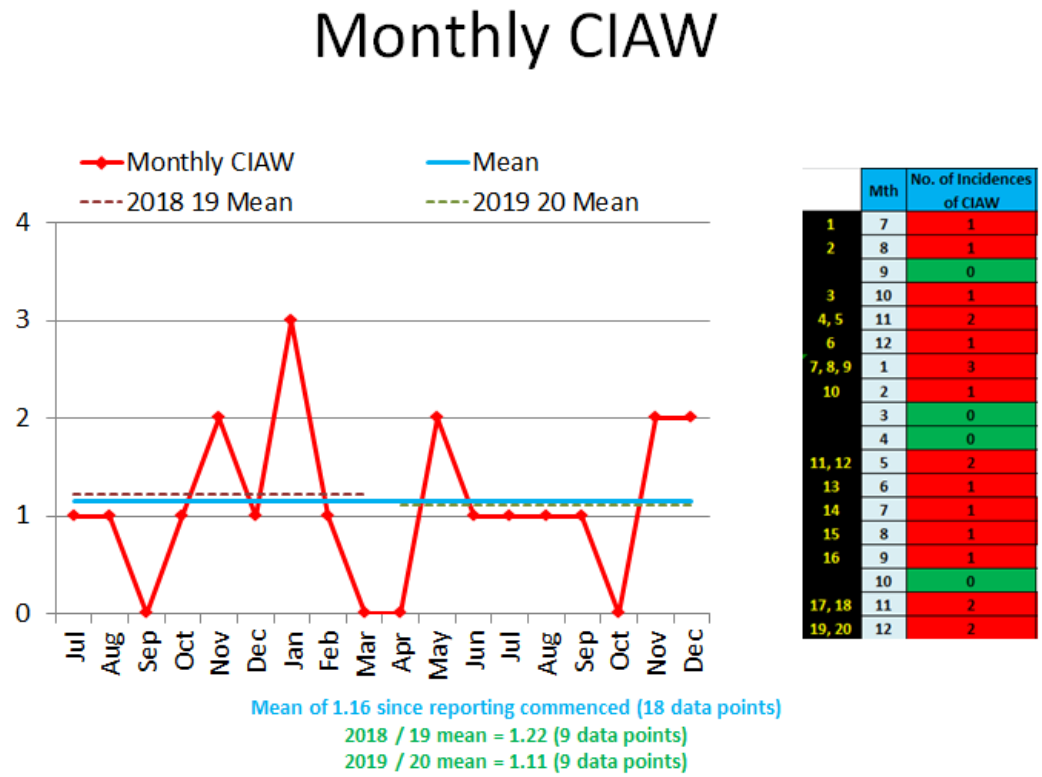
A daily report from the Trust Information Team highlighting any child admitted to an adult ward continues to be reported on a daily basis to appropriate staff. The monitoring of admission information also continues to be undertaken by the Liaison Nurse for Age Appropriate Care in order to demonstrate that these children have been admitted appropriately to cohort wards. Patient satisfaction surveys and other patient feedback remains generally positive.

3.2 Children in Adult Wards (CIAW) Activity Monitoring

As previously noted a number of activity monitoring processes are in place to ensure patients up to their 16th birthday are admitted to paediatric settings where this is clinically appropriate, including:

- A Daily report of Admissions & Transfers In to Adult Wards Age under 16 years;
- A Children in Adult wards tracker tool; and
- A weekly report of 14 & 15 year olds by admission/Discharge and by Ward.

The below graph provides details of admissions of paediatric patients to adult wards since July 2018 to December 2019.



	Mth	No. of Incidences of CIAW
1	7	1
2	8	1
	9	0
3	10	1
4, 5	11	2
6	12	1
7, 8, 9	1	3
10	2	1
	3	0
	4	0
11, 12	5	2
13	6	1
14	7	1
15	8	1
16	9	1
	10	0
17, 18	11	2
19, 20	12	2

In comparison to 2018 / 19 monitoring (249 days), 2019 / 20 YTD monitoring (275 days) evidences:

- 9.0% reduction of CIAW occurrence based on average number of CIAW incidences per month (1.22 improved by 0.1 to 1.11).
- 10.4% increase in average number of calendar days between CIAW incidences (24.9 improved by 2.6 to 27.5).

All admissions were followed up and determined to be appropriate placements based on clinical need with paediatric support where required

3.3 BMJ Learning Module

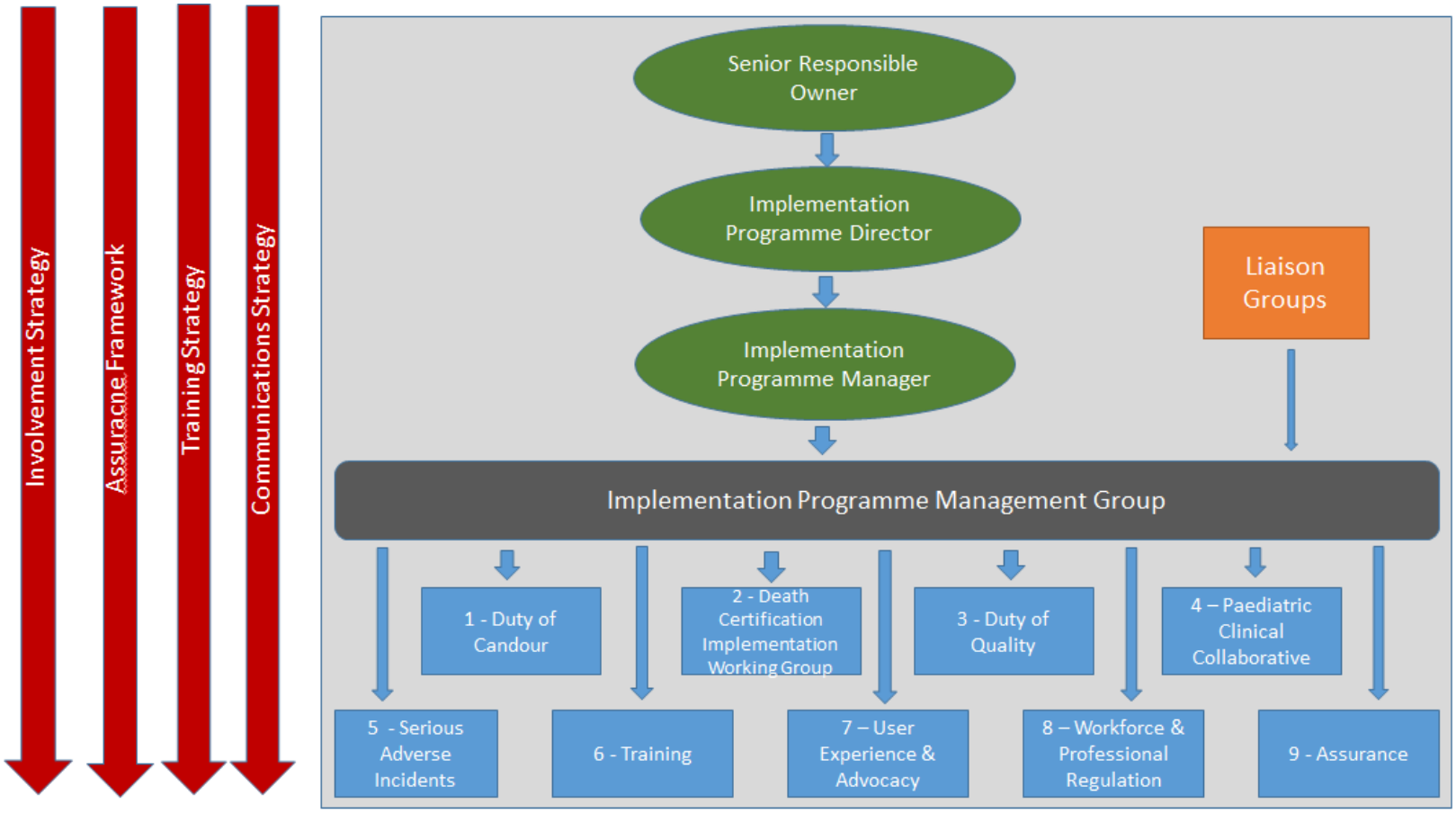
To support reducing the risk of hyponatraemia when administering IV fluids to children aged, over 4 weeks and up to 16th birthday, all professionals involved in treating children must ensure that their practice meets the knowledge and competency framework set out regionally and meets the training requirements of their individual Trust. A core component of developing the prerequisite competencies is completion of the British Medical Journal (BMJ) e-learning module ‘Reducing the risk of hyponatraemia when administering IV fluids to children’.

Prior to the spring of 2019 access to this module was free, at which point the BMJ introduced an access charge, without prior notification, to be levied on an individual or organisational basis. To ensure continuing HSC access the PHA provided funding until 29 February 2020. However, it has recently been confirmed that this funding will not be recurrent. Therefore to ensure continued access, a regional contract has been established and will be centrally managed by the BHSCT, to which the Trust will contribute its share of £10,787.07 for the twelve month period commencing 1 March 2020.

South Eastern Health and Social Care Trust

Appendix 1

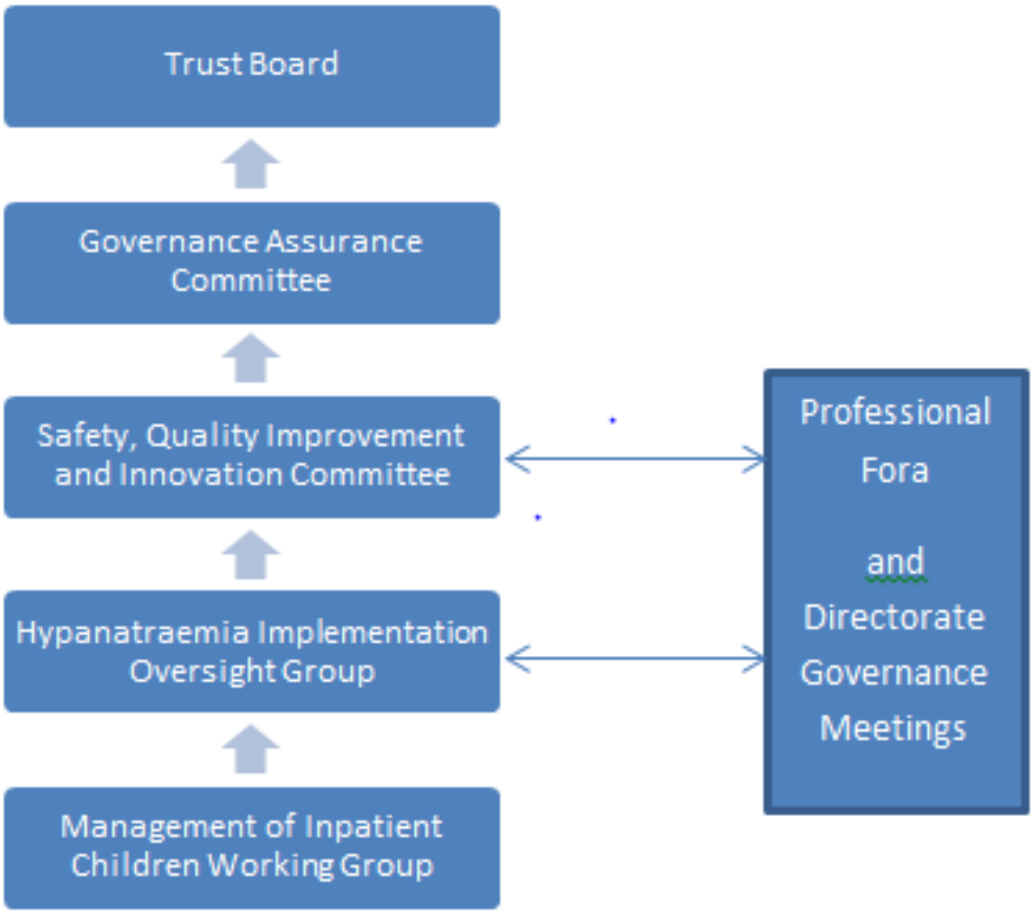
IHRD Programme Structure



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**
Jonathan Patton	**Non-Executive Director**
Helen Minford	**Non-Executive Director**
Joan O'Hagan	**Non-Executive Director**
David Robinson	**Interim 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 Robert Kennedy	**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**
Kieran Quinn	**Interim Assistant Director WACH**
Irene Low	**Assistant Director Risk Management**
Jill Macintyre	**Head of Pharmacy & Medicines Management**
Eunice Strahan	**Safe & Effective Care Manager**
Teresa Mungur	**Clinical Manager Paediatrics and Neonatology**
Paul McCloskey	**Bereavement Coordinator**
Scott Hyvart	**Clinical Governance & QI Officer**
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