Hyponatremia Related Deaths Inquiry Report

A joint response

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Hyponatremia Related Deaths Inquiry Report

A joint response by:

Royal College of Paediatrics and Child Health
Royal College of Surgeons (England)
Royal College of Surgeons (Edinburgh)
Royal College of Anaesthetists
Royal College of Pathologists

With thanks to the Royal College of Nursing for their input

Introduction

Sir Justice O'Hara's report raises serious concerns about the standard of healthcare delivered to five children who tragically died in Northern Ireland as a result of hyponatremia related illnesses between 1995-2001. The report also identified system failures in the investigation of the deaths. Our thoughts and deepest sympathy lies with the families of Adam Strain, Claire Roberts, Lucy Crawford, Raychel Ferguson and Conor Mitchell who suffered the devastating loss of a child.

The inquiry reported serious concerns around the circumstances of each death and ruled that three of the deaths were preventable. It identified system failures in the care and investigation of the deaths and concluded that the patient harm and suffering caused by medical errors was compounded by a flawed culture which displayed a lack of honesty and transparency.

Doctors and other healthcare professionals do make mistakes and we must admit to those mistakes when they are made. It is also vital that we learn from these mistakes and everything possible is put in place so they are never repeated.

Whilst Justice O'Hara's report recognises that improvements in health practice in Northern Ireland have been made in the years since these deaths, it is right that further improvements are needed to deliver high-quality transparent services, where errors are rigorously investigated and the right people and authorities are held to account if things go wrong.

The alarming findings of this inquiry demand the urgent attention of all healthcare institutions, those working in the NHS and the Department of Health. I hope this

response from the membership bodies of healthcare professionals demonstrates the commitment and desire of doctors and nurses to work with patients, the Trusts and the Department of Health to provide a safe and effective health service based on honesty, transparency and accountability for all the patients we serve. We look forward to getting to work on implementing the improvements needed.

Dr Karl McKeever, Officer for Ireland, Royal College of Paediatrics and Child Health

The response

Healthcare professionals including paediatricians, surgeons, pathologists, anaesthetists and nurses have come together to consider the report, its implications for practice and to review the recommendations.

The response covers each of the sections of the report. We provide an overarching comment for each section, then highlight specific recommendations that we feel need further clarification – making suggestions for how they may be practically implemented. We also point to existing resources and guidance from our respective organisations that may be useful to support the implementation of the recommendations.

Where a specific response on a particular recommendation is not included, it can be taken that we agree with the recommendation in its current form.

We welcome the depth of consideration of the important and very concerning issues raised within the report and commit to working together to achieve implementation of agreed recommendations, where necessary identifying and seeking support to make sure required resources are available.

We hope that, in addition to guiding our own professional response and actions, this response is useful for decision makers and that it results in real change to improve the delivery of children's healthcare in Northern Ireland and beyond. We also hope this gives some assurance to the families, and to Justice O'Hara QC, that the medical and nursing professions are listening and working towards ensuring these recommendations are implemented meaningfully and usefully in the treatment and care of children.

As a multi-agency group, we would like to meet with the Department of Health to help inform the strategic response to the report. We also think that including patient representation in this is vitally important.

Key themes:

- Honesty and transparency within the health system is vital
- We propose a review of how accountability can be extended to the conduct and performance of health care managers to further embed safety within the system
- Children, young people and parents/ carers should be invited to co-design services and shape models of care
- Sufficient time must be allocated for training and learning for healthcare professionals
- There should be increased use of E-health to enhance patient safety
- There is a need to ensure the continued local provision of the surgery of childhood in line with the Federation of Surgical Speciality Associations guidance (2018) on the local delivery of surgery in childhood
- There are nuanced differences between 'responsible' and 'accountable' – and these need to be properly considered

1. Candour

Honesty and transparency is vital in healthcare and should be embedded in the culture of the health system. We agree with the principle of openness and honesty within the NHS. Patients and carers have the right to know when mistakes are made, what the consequences are or may be, and what action has been taken not only to correct mistakes but to prevent similar occurrences in the future. They should have access to information regarding the care and safety of their child.

1.1. Specific recommendations

Recommendation 1: A statutory duty of candour should now be enacted in Northern Ireland.

The development and implementation of a statutory duty of candour should be a high priority item for the report working group taking into account a duty of candour is already a professional requirement. The utility of criminal liability and its potential impact on patient safety must be carefully assessed. In addition, extensive work is required to unpack the implications and potential operational demands resulting from the possible introduction of a "whistle-blower" policy.

Recommendation 2: Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.

As Royal Colleges we represent individuals who followed a defined training and career structure and who are regulated by professional bodies. While this system is imperfect and there will always be individuals who evade the notice of authorities, regulation does provide a route by which unsafe practice can be identified and tackled, preventing that individual from causing further subsequent harm.

We believe similar oversight should also apply to managers, given their power and influence within healthcare organisations.

We would support a review of how this can best be achieved. We recognise it might be difficult to replicate the same model of regulation for doctors or nurses given there are no recognised mandatory qualifications for managers linked to a license to practice. Options could include a regulatory body or following a similar scheme to England's 'Fit and Proper' test.

Lord Francis has previously supported formal regulation of NHS managers. Consideration should be given to a review of the standards of conduct we expect of senior NHS managers. In the post-Francis era, NHS England managers are already expected to comply with the 'Seven Principles of Public Life'. A revised Code of Conduct could describe how managers could be held to account when system failures occur. These processes would provide a triple lock governance with nursing, medical and managerial accountability protecting patients.

The GMC has commissioned a review, led by Dame Claire Marx, into medical negligence manslaughter. Consideration should also be given to reviewing the Scottish model of culpable homicide as a credible alternative legal process of accountability and redress.

We also believe there is merit in Sir Ian Kennedy's recent comments calling for more timely redress for patients and families who suffer harm with financial compensation.

Recommendation 6: Support and protection should be given to those who properly fulfil their duty of candour.

We support the creation of a 'Patient and Staff Safety Council' (PSSC). The PSSC would safeguard patient and staff rights, including standardisation of both group's recourse to complaint and interrogation of the HSC and Trusts. The PSSC would be independent of Health Trusts and directly accountable to the Health Minister with provision of support and protection to individuals who report concerns to the PSSC.

Further detail of what support and protection looks like and how this can be accessed needs to be developed (see also Recommendation 38).

1.2. Existing resources:

- Duty of Candour guidance and e-learning from the Royal College of Surgeons (England)
- The Royal College of Nursing has a helpline for nurses who want to report issues of concern
- Working together to improve the local delivery of the General Surgery of Childhood – Statement of Intent
- NHS England "Fit and Proper" test
- Recent GMC position on the Hyponatremia Related-deaths Inquiry recommendation: See "Candour" Page 4. (Concerns raised that a punitive duty backed by criminal sanctions could be counter-productive)

2. Leadership

Recommendation 9: The highest priority should be accorded the development and improvement of leadership skills at every level of the health service, including both executive and non-executive Board members (etc).

We recognise that strong leadership at every level is key to the provision of safe and effective healthcare. Too often the emphasis is on top-down leadership. This is a unique time to further improve effective leadership in the context of the Department of Health Collective Leadership Strategy.

Investment in Continuous Professional Development (CPD) time for all professionals varies between professional groups and Trusts. There is no consistency in funded release time, including medical consultant Supporting Professional Activity (SPA) time, and most leadership training is undertaken in an individual professional's/ consultant's own time. In order that clinicians can make good use of existing resources and become empowered as effective leaders within the whole system, we recommend including designated time for leadership training and for actual leadership activity, including consideration of allocated Programmed Activities (PA) and supernumerary time for nurse leaders.

2.1 Existing resources:

- RCPCH Progress, the new curriculum for paediatric medical training introduces leadership skills from day one of training, being an integral part of generic Level 1. This is much earlier than ever before.
- RCPCH Clinical Leadership Programme and associated resources
- RCN Breaking down barriers, driving up standards

3. Paediatric – clinical

This section covers a number of areas, including age-appropriate settings for children being treated in hospitals, recording of drugs, attendance on ward rounds and who has overall responsibility for the care of a child. Whilst we agree with the sentiments of the majority of the recommendations, we have real concerns about whether some of the proposals will work in practice and of the unintended consequences that may arise. These are highlighted below.

3.1. Specific recommendations

Recommendation 10: 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.

Children and young people must be treated as close to home as possible in an age-appropriate environment by appropriately trained staff. Children's surgical services should be provided via networks linking specialised and local providers as recommended in 'Configuration of Services' available at Standards for Children's Surgery, Children's Surgical Forum and the recent FSSA publication –'Working together to improve the local delivery of the General Surgery of Childhood - Statement of Intent, April 2018'.

Currently the age for admission varies between units. In some instances, such as the vulnerable child, learning difficulties, or developmental issues, transition to adult services may not be in the young person's best interests. The delivery of the best model of care here can be very challenging for the whole service. It can be difficult to achieve the ambition of age-appropriate settings due to insufficient beds and staffing pressures. In addition, a child can have a very different physical and developmental age and therefore age limits are hard to define. We recommend a regional, joined-up approach, which also includes young peoples' own views on when it is right for them to transition to adult services, in order to make this a reality. This could be delivered via the Paediatric Network/ Child Health Partnership, drawing on the expertise and previous work on age limits by the HSC Patient Safety Forum: Paediatric Collaborative.

Recommendation 11: There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.

There are currently different protocols in place, with some commonalities, for example drugs charts do get taken with the patient. We suggest adding to this recommendation the development of a specific transfer form, to include existing data, and using PRSB standards.

We further suggest that all children should have a single digital medical record. This would ensure standardised transfer of care documentation between sites and within teams.

Recommendation 12: Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.

This requires clarity in terms of what 'overall responsibility' means. Rather than overall responsibility for all individual children admitted resting with a named paediatric consultant (who may not be involved in any way in a child's care, particularly if they are, for example, admitted for surgery), there should be absolute clarity at all times as to the on-call paediatrician, with a clear process for how they can be contacted e.g. by a surgeon or nurse.

Guidance and standards can be found at Standards for Children's Surgery, Children's Surgical Forum. This guidance (page 4) recommends that a named consultant paediatrician must be available for liaison and immediate cover, for example in cases of children requiring on-going care following resuscitation, and to advise on safeguarding issues. While such situations are rare, the level of cover should ensure attendance within 20-30 minutes. In addition, the guidance states that the on-going care of inpatients/ postoperative patients should be managed by consultant surgeons, with support from consultant paediatricians where necessary.

Further guidance is available in the 2015 CSF document 'Standards for non-specialist emergency surgical care of children'. Page 32 of this document states that:

> *Where children are admitted with surgical problems, their care should be jointly managed by teams with competencies in both surgical and paediatric care. Children admitted for surgery – whether in inpatient, day care or short stay facilities – have a named consultant surgeon and a named paediatrician with timely attendance and urgent review when required.*

It further recommends that there is defined access to a named consultant paediatrician review, if required, of any young person who has been admitted to an adult ward. The guidance also recommends that hospital inpatients are reviewed by a consultant surgeon at least once every 24 hours, 7 days a week.

There must be a clear pathway for escalating concerns and for obtaining paediatric advice, support and intervention.

Recommendation 13: Foundation doctors should not be employed in children's wards.

We strongly disagree with this recommendation. F2 doctors are a valuable and integral part of current paediatric and neonatal teams, safely working in children's wards across the UK. In some UK Deaneries, such as London & South East deaneries, F1 doctors currently have a four-month placement in safe and supervised paediatric environments. Without F2 doctors there would be a serious impact on workforce capacity, service provision, and indeed a longer- term issue with recruitment into paediatrics. Robust safety arrangements are already in place with agreed standards of provision of suitable supervision and support for F2 doctors from more senior trainees and consultant paediatricians. Further consideration of this along with the Northern Ireland deanery may be useful as we cannot have a different foundation programme from the rest of the UK.

Recommendation 14: The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.

This already happens as part of the CCT, so this recommendation would result in unnecessary duplication and the resource required could be better used in strengthening existing arrangements. All staff doctors are regulated by the GMC and all nurses by the NMC and must be competent in fulfilling their role.

Recommendation 15: A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.

Although this already happens, we recommend inserting the word 'appropriately' to clarify that consultants are informed of changes to the patient's condition that the doctor or nurse feels are significant, or if they are unsure or concerned. Otherwise there is a danger of unnecessary reporting, taking up valuable time with no increase in patient safety. 'Appropriately' must come with set operational policies as to when to inform a consultant regarding an unscheduled admission and which include escalation systems if there is a need to raise concerns to senior staff. The circumstances in the RBHSC may well differ from that in District General Hospitals and should be considered.

Recommendation 16: The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.

With respect to the name of the nurse accountable for the child's care being placed on a board above the child's bed – we interpret this as the name of the nurse caring

for the child on any given shift (i.e. the 'responsible nurse') – and this practice is already in place in many organisations. For those organisations that do not have boards behind a child's bed, they have some means of this information being on display on the bed itself. This information is crucial not just for parents/ carers but indeed for other members of the multi-disciplinary team to know which nurse to speak to regarding the child's care. We would agree that this nurse insofar as is possible should attend any discussion regarding the child's care but the reality is that a nurse will have a number of patients to care for and cannot always be readily available.

Guidance from the Children's Surgical Forum (2015) and from the Royal College of Surgeons (England) (Good Surgical Practice 2014) emphasise the need to be clear to staff, patients and families about who is responsible for the care of a patient. Good Surgical Practice recommends that "Where care is being jointly managed between different teams or specialties, the responsibilities of different teams are explicit and are made clear to patients and families".

The CQC has stated that there is no confidentiality issue in naming both the patient and the consultant with overall responsibility by the bedside. This guidance should be disseminated to all staff managing the care of children and should be implemented across the HSC.

Recommendation 20: Children's ward rounds should be led by a consultant and occur every morning and evening.

We do not believe that having a consultant lead two ward rounds a day is the most effective way of ensuring patient safety/ improving patient care. There is a risk that, with too many healthcare staff expected to be on a ward round, the crucial work of nurses actually delivering care and practically looking after patients will not be possible due to time constraints. Safe and effective handover of decisions made during a ward round is an effective tool which ensures implementation of prescribed care.

There is extensive evidence that safe and standardised consultant-led handovers (in addition to ward rounds and clear, effective communication lines) provide high standards of safe care. Whilst a standardised approach is important, workforce pressures and job plans mean that it is impossible for consultants to see every patient every morning and every evening.

The standards outlined in Facing the Future – where every new patient is seen by a consultant within 14 hours of admission, and where consultants should lead two handovers each day and be present at peak times during weekdays and weekends, should be implemented. The standards also state that all general paediatric inpatient units adopt an attending consultant system, which is most often delivered in the

form of the 'consultant of the week'. This means that a consultant should always be available if required.

In relation to ward rounds specifically, a consultant should be available in a timely way – and consideration should also be given to 'virtual' ward rounds; where consultants are on hand to give telephone advice. Other patient safety innovation can be found at Situational Awareness For Everyone which, among other things, strives to reduce avoidable error and harm to patients and improve communication between healthcare staff, families and patients.

Recommendation 21: The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.

Although a laudable aim we are concerned at how this might work in practice, with interactions between healthcare professionals and patients happening 24 hours a day and with nurses involved in the delivery of care to a number of patients.

Recommendation 23: The care plan should be available at the bed and the reasons for any change in treatment should be recorded.

Appropriate and clear documentation is important. We agree that parents/ carers should have supported access to what is written in a child's care plan with clear processes and guidance on how to aid parental/ carer understanding of what is written, and to promote a partnership approach so that the care planned meets the specific needs of their child. However, in cases where there are child protection concerns, or suspected fabricated or induced illness, there will need to be exceptions, and this should be made clear.

Recommendation 24: All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart.

We agree with this, and would add that whoever orders the blood test should take responsibility for chasing up the results (and this should be documented). In addition to sodium levels, potassium levels should also be recorded on the charts.

Recommendation 25: All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction, the pharmacist should inform the prescribing clinician.

This currently happens in the form of the 'drug kardex' – held separately from clinical notes and supported by a digital prescribing tool. Whilst we agree with a daily list of all current drugs, and a note for any change in prescription in the clinical record (as is currently the case), we don't agree that all instances of administration should be in

the notes. It would be wasteful duplication of time that will not add to patient safety.

Clarity is required on whether or not this recommendation applies to the issue of prescribing by anaesthetists in the operating theatre, as what is prescribed there is separate from the drug kardex and is documented on an anaesthetic chart and not the patient's notes.

The availability of paediatric pharmacists and electronic prescribing are widely recognised to improve care and reduce mediation errors. We strongly recommend the provision of a paediatric pharmacist for each children's ward be made a mandatory requirement.

Electronic prescribing should be extended to all children's wards.

Recommendation 26: Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.

Whilst we agree with the principle of this recommendation, in reality if clinician includes nurses who will be in conversation with parents 24/ 7, this is impossible. We would recommend that this recommendation states that any significant information, including changes in condition or the care plan, are highlighted – not necessarily all discussions – so a more pragmatic approach is adopted. The information recorded could also include significant observations made by parents. We would welcome guidance on what constitutes 'significant.'

Recommendation 28: Consideration should be given to recording and/ or emailing information and advices provided for the purpose of obtaining informed consent. Information should be given to all healthcare professionals on informed consent (see RCSEng guidance below)

3.2. Existing resources:

- Informed consent (Royal College of Surgeons – England)
- The role of the supernumeracy/ supervisory ward sister/ charge (Royal College of Nursing)
- Facing the Future Standards (Royal College of Paediatrics and Child Health)
- Guidelines for the Provision of Paediatric Anaesthesia Services 2018 (Royal College of Anaesthetists)
- Standards for Children's Surgery (Children's Surgical Forum)
- Situational Awareness for Everyone (S.A.F.E.)

4. Serious Adverse Clinical Incidents (SAIs)

We agree with the ambition of these recommendations, and have a number of suggestions for how these could be practically implemented.

4.1. Specific recommendations

Recommendation 31: Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents (SAIs).

This is covered within the new paediatric curriculum – 'Progress' under Domain 8.

Recommendation 32: Failure to report an SAI should be a disciplinary offence.

We propose a change in wording to 'should be investigated as a disciplinary or potentially a criminal offence'. Questions remain about what stage incidents should be reported, not least because incidents are often deemed 'serious' in retrospect and furthermore the definition of an SAI can vary, which is bound to cause challenges in complying with this recommendation.

Recommendation 34: The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.

Whilst we agree with this, we suggest that the reviewer does not necessarily need to be outside Northern Ireland – as long as they are able to demonstrate no conflicts of interest. We agree with the principle of having a Trust regulator – with similar powers and remit that the GMC has for individuals (see Duty of Candour, Recommendation 2, above).

Recommendation 37: Trusts should seek to maximise the involvement of families in SAI investigations (etc).

The 'Bengoa' report and 'Delivering Together' recognise the important role of patients and their carers in the delivery of high quality services. Both reports call for a stronger patient voice. The Inquiry found that bereaved parents did not on occasions feel their concerns were listened to and felt powerless to contribute to the care of the child. As stated in Recommendation 6, we support the creation of a 'Patient and Staff Safety Council' (PSSC) to safeguard and promote the rights of patients and their families to play a full role in the care of their loved ones and have prompt recourse to complaint and redress when things go wrong.

To enact these recommendations, we also suggest including the development of a 'Children's Healthcare Charter'. It is crucial that service users (children and their families) are part of service design, including after serious adverse clinical incidents. We also believe that a truly patient-centered service would incorporate patient advocacy and therefore there wouldn't be a need for a separate service.

Recommendation 39: Investigation teams should reconvene after an agreed period to assess both investigation and response.

Although this is already part of many hospitals' practice, evidence suggests it is often done poorly. We suggest adding a timeframe to this recommendation for added clarity.

Recommendation 41: Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.

We agree with this, but suggest adding in the importance of disseminating learning, rather than simply publishing a report. Standards of best practice around dissemination of learning from medical errors, including incident report forms, should be drawn up to ensure compliance and accountability.

We also recommend that the reports are made available in an understandable format for parents.

In addition, it is important to acknowledge that the confidentiality of all staff, as well as patients and families, needs to be respected.

Recommendation 51: Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.

The Trust legal team should look at all witness statements made by any of their employees before they are sent to the Coroner. This is current good practice. In addition, we would support the development of an independent service which steps in at the time of a serious adverse incident, or death, to remove the possibility of Trust interference.

Recommendation 53: In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.

Further clarification is needed on the definition of 'legal privilege.' We don't believe there should be any obstruction to honesty and transparency.

Recommendation 54: Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.

In addition to the current wording, we feel it should be highlighted that bereavement services must also clearly co-ordinate those associated with normal circumstances, SAI circumstances and coronial processes.

5. Training and Learning

Ensuring up-to-date and appropriate training and learning for healthcare professionals is vital. In order for this to be properly enacted, there must be sufficient time allocated for training within a healthcare professional's contracted hours.

5.1. Specific recommendations

Recommendation 55: Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.

We agree with this recommendation as a starting point but strongly advise that new models of regulations and accountability to assess the performance of medical managers and Trusts should be developed.

Recommendation 57: Specific clinical training should always accompany the implementation of important clinical guidelines.

This recommendation is fully supported and guideline release should be associated with training, whether a Royal College, National or local guideline.

Recommendation 58: HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatremia.

It is currently mandatory for all nurses and doctors working with children and young people to complete training in paediatric fluid management and hyponatremia and to renew this every three years. Successful completion of this is an essential part of consultant annual appraisal.

Recommendation 59: There should be training in the completion of the post-mortem examination request form.
We suggest that the clinician performing the post-mortem not only takes responsibility for ensuring consent is gained appropriately, but also takes some responsibility for training local clinicians.

Recommendation 61: Clinicians caring for children should be trained in effective communication with both parents and children.

This is included in the current and the new paediatric curriculum as well as the START assessment. All workplace-based assessments are testing communication skills. We support training for other specialities and health professionals and there is a domain on communication across all levels of the new generic curriculum.

We suggest adding the requirement for a three-yearly refresher course.

Childrens' nurses are trained in effective communication with parents and children. Therefore, all children should be cared for by childrens' nurses, and if nurses are from another field of nursing they should receive training in effective communication with children.

We urge that children and young people should be involved in developing, implementing and evaluating elements of training programmes such as these.

Recommendation 62: Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after an SAI death.

We agree with this recommendation, and believe that this training should be formal. Parents and carers should be involved in developing, implementing and evaluating elements of such training programmes.

Recommendation 63: The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.

We agree with this recommendation, and believe that training needs, identified through evaluation, should be included in CPD provision. It is presumed that 'families' includes patients and we suggest this could be made clearer in developing this recommendation. Parents, carers, families and patients should be involved in developing elements of the evaluation methodology.

Recommendation 67: Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.
The RCPCH sets standards in this area, and include specific scenarios in the Specialty Training recruitment stations and in START assessment.

The local training institution and NMC should be informed if there is inadequacy in an NMC approved HEI nurse training programme.

5.2. Existing resources:

- Innovative new trainee led ACTup course set up in Northern Ireland and run by paediatric trainees. It focuses specifically on difficult communications around medical/ ethical issues but could be extended to challenging situations around SAI.

- RCPCH &US: an innovative and successful platform for children, young people, families and carers which promotes effective strategic and operational engagement.

6. Trust governance

Recommendation 69: Trusts should appoint and train executive directors with specific responsibility for: (i) issues of candour (ii) child healthcare (iii) learning from SAI related patient deaths.

We seek clarification as to how the proposed executive director roles varies from the current child health directors and the Deputy Chief Medical Officer (Children's Healthcare) – as per Recommendation 85. Furthermore, this proposal would not deliver independent regulation and could itself hinder full candour and learning.

Recommendation 73: General Medical Council (GMC) 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.

This recommendation would put Northern Irish doctors in a different contractual position to the rest of the UK, with regard to GMC guidance. The principle may be good but the practicalities need to be considered.

Recommendation 74: Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.

Again, this recommendation would put Northern Ireland in a very different legal position to the rest of the UK. The principle may be good but the practicalities need to be considered.

Recommendation 75: Notwithstanding referral to the GMC or other professional body, Trusts should treat breaches of professional codes and/ or poor performance as disciplinary matters and deal with them independently of professional bodies.

The implications of any departure from existing, established referral procedures for possible disciplinary matters in favour of Trust oversight, independent of professional bodies, needs further consideration as it would either alert or duplicate current Government regulation by the GMC. For public safety this recommendation must not be seen as a local alternative, limiting appropriate or timely referral to professional regulators.

7. Department

We agree with all the recommendations stated in this section.

Recommendation 85: The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.

We are strongly supportive of the appointment of a Deputy Chief Medical Officer with specific responsibility for children's healthcare. This would assist the Department to fulfill its legal obligations as set out in the United Nations Convention on the Rights of the Child (UNCRC): Article 4 and Article 24.

'Delivering Together' clearly identifies effective leadership as an essential ingredient of high-quality health systems. The provision of strong leadership for child health professionals is a central tenet of the reforms needed to improve patient care and outcomes. A deputy CMO for child health would provide the strategic vision for high quality, equitable and accountable child healthcare in Northern Ireland and the allow better transfer of information and learning across child health systems here.

Recommendation 86: The Department should expand both the remit and resources of the RQIA (etc).

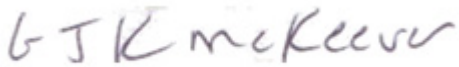
We are supportive of the expansion of the resources of the RQIA, however as referenced under Recommendation 2, we support a review of the systems in place to regulate medical managers with due consideration being given to the establishment of a regulatory body for medical managers, with statutory provisions to protect patients and HSC employees. This regional HSC body would hold Trusts to account and include oversight of the SAI process, strengthened capacity to investigate and review individual or group cases and scrutinise adhered to the duty of candour. It is also important that there is a mechanism for investigating systemic failings within Trusts.

Recommendation 88: The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.

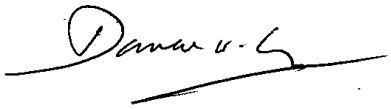
A Child Death Overview Panel should be constituted as a matter of urgency, as called for by the NICCY & RCPCH.

8. Culture and litigation

Further discussion with expert bodies is required in relation to all three of these recommendations.

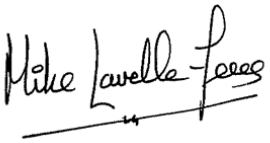


[Karl McKeever] Royal College of Paediatrics and Child Health



[Darrel Lowrey] Royal College of Anaethetists

[Lance Sandle] Royal College of Pathologists



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