Saving lives, Improving lives

NHS
North Manchester Care Organisation
Northern Care Alliance NHS Group
Medical Director
North Manchester General Hospital
Delaunays Road
Crumpsall
Manchester
M8 5RB

[redacted]

[redacted]

Date: 20 March 2020

[redacted]

Private & Confidential

I write to you in response to your correspondence dated 21 January 2020. Thank you for bringing the concerns raised in the paragraph 37 letter report to my attention, I apologise that you have had to write to me with further concerns. The Northern Care Alliance is dedicated to ensuring patient safety is maintained throughout all services.

I would like to take this opportunity to provide assurance to both you and the family that the Trust takes the concerns raised very seriously and have conducted a thorough review. At the outset please pass on my sincere condolences to the family, I am sorry they have been given cause for concern at such a difficult time.

The concerns you have raised have been reviewed and addressed by the senior leadership team. In order to answer each point I have set them out below for ease of reference:

Assumption regarding access to specialist services

It was incorrectly assumed that, given Master Kaye was under the Community Paediatric Team, he would also have been receiving input from specialist services or, in the alternative, his psychological health would have been assessed by the Community Team during the planned review in June 2017. I am aware that my colleague [redacted], Consultant Paediatrician and Clinical Director for Paediatrics, was at the inquest and has de-briefed his colleagues regarding this. Please accept our sincere apologise for this error.

As you are aware, in order to avoid any confusion and the risk of some children not being followed up with appropriate mental health input, the process of discharge for every child attending at any Trust hospital, in circumstances such as Master Kaye, has now changed. All children who present to Accident and Emergency with an overdose (irrespective of whether it is suspected and / or subsequently ruled out) will be the subject of a Healthy Young Minds / CAMHS referral. This message has been relayed to the emergency department and paediatric staff (at all sites).

As a direct consequence of the issues raised at inquest, [redacted] has instigated a meeting, between Pennine Acute and Pennine Care / HYM to discuss the referral process, explore whether it can be clarified and whether there are any improvements that can be made. This meeting is due to go ahead on 25 March 2020 with governance leads and senior managers in attendance, including:-

- [redacted], Consultant Paediatrician and Clinical Director for Paediatrics – PAT
- [redacted], Consultant Child and Adolescent Psychiatrist - Clinical Director HYM (North Division)
- [redacted], Consultant Child and Adolescent Psychiatrist - Clinical Director HYM (South Division)
- [redacted], Consultant Child and Adolescent Psychiatrist – HYM

- [redacted], Deputy Managing Director – HYM
- [redacted], Patient Safety Lead – HYM

For the avoidance of doubt, the current process of referring any child with a suspected psychological issue stands, until a better alternative (if it exists) is agreed at this meeting. The learning and outcome of this meeting will then be disseminated Trust wide.

On 22 January 2020 a paediatric departmental teaching session took place. Much of that session was devoted to the learning arising from the Serious Case Review and inquest.

The Community Paediatric Team do have access to all medical records and will have been able to consider Master Kaye's acute admission in April prior to reviewing him in June 2017. Unfortunately, on this occasion, it is not documented whether this was explored. [redacted] is aware of this and has raised it with [redacted], Consultant Paediatrician and Community Paediatric Lead, who in turn has provided feedback to her team.

I will be sharing this response with [redacted] and will be asking him to again reiterate to his team the importance of never assuming that just because a patient is under the care of the Paediatric Community Team that they will also be receiving input from the necessary specialist services.

Safeguarding referrals

I apologise that the evidence given to the Court gave the impression of a narrow understanding of safeguarding and the circumstances in which a safeguarding referral may be required.

In my own experience, Northern Care Alliance NHS Group (NCA) staff are well versed in when a safeguarding referral is needed and there is good awareness of the need to consider a referral – irrespective of whether the patient presents with a physical or potential psychological issue.

[redacted] has discussed the issues raised at inquest with the clinical directors for Accident & Emergency at Fairfield, Oldham and North Manchester. They in turn have communicated the learning from the inquest within their teams.

The Trust acknowledges that training and communication are essential in ensuring that everyone knows what safeguarding means and when and how it should be acted upon.

In November 2019 the Trust ratified a new safeguard training strategy (enshrined within a formal policy) to provide additional assurance on the focus we have on safeguarding training. This strategy will enable the Care Organisations across the NCA to discharge their statutory duty to safeguard and promote the welfare of children. It is in line with the current statutory guidance 'Working Together to safeguard children' (DFE, 2018) and will be reviewed against any future guidance to ensure compliance under Section 16 of the Children Act 2004.

The training on the safeguarding of children and adults is now a mandatory course to be undertaken on induction to the Trust. Safeguarding E-Learning modules are also included within the pre-employment induction pack.

To protect children and young people from harm, and help improve their wellbeing (whether physical or mental), the NCA ensure that all healthcare staff must have the competencies to recognise child maltreatment, opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role. This Training strategy provides a clear framework which identifies the competencies required for all healthcare staff. At inquest, I understand that you heard

evidence on the different levels of training; levels 1-3 relate to different occupational groups, while level 4 and 5 are related to specific roles. All newly employed staff will now undertake the combined level 1 and level 2 safeguarding children E-learning training within 1 month of employment. This combined session covers the basic principles of safeguarding children and young people from potential harm (both physical and psychological) and provides details of who to contact for advice and support if a safeguarding concern arises.

The combined programme provides core safeguarding / child protection training (level 1 and level 2 training). This level of training builds on the competencies outlined for level 1, covering in more detail the understanding of child maltreatment, the role of the practitioner in identifying and responding to potential abuse and the need to act as an advocate for the child/ren in their care.

This programme provides staff with an understanding of the child protection legal framework and the processes for making referrals to social care and other external agencies as required. It also ensures consideration of ethnicity, culture, race and religion (of particular relevance in Master Kaye's case) and highlights lessons learnt from serious case reviews.

The e-learning programme is repeated as a 3 yearly update as part of the core mandatory training programme. All clinical and non-clinical staff must complete the safeguarding children and young people module as part of their mandatory training requirement.

Training is delivered or overseen by experienced safeguarding professionals from the corporate safeguarding team, via the multi-agency training pools supported by Local SCP's and SAB's and by approved guest speakers.

I am confident that this new training strategy will ensure that the NCA are where we need to be in the identification of safeguarding issues (the whole spectrum) and how then to act upon them.

The NCA also has in place a specific safeguarding policy for children. That policy emphasises that safeguarding is everyone's responsibility and therefore all staff - clinical and non-clinical (acute and community), volunteers and staff contracted to NCA need to appreciate that safeguarding is for everyone and that everyone is under a duty to raise concerns. All staff have easy access to this policy on the Trust intranet.

In addition to the above, an action plan was developed following receipt of the Serious Case Review and the recommendations have been appropriately acted upon.

I do hope that this correspondence reassures you that the learning following the inquest has been reviewed in detail. I trust the above information addresses all the concerns raised; however, if you any further concerns please do not hesitate to contact me. The Trust would also be happy to meet with the family should they find that helpful?

I would like to conclude by reiterating my sincere condolences to them at this difficult time.

Yours sincerely,

[redacted]

[redacted]

Medical Director North Manchester General Hospital