Royal College of Paediatrics and Child Health
Leading the way in Children's Health

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Dr Dominic Bell
Assistant Coroner
Hull and the East Riding of Yorkshire

25 July 2022

Dear Dr Bell

Re: Esma Guzel, aged 5 years

Thank you for sharing your Letter of Concern with us regarding the tragic and untimely death of Esma Guzel. We were saddened to read the circumstances surrounding this child's passing and have discussed with senior colleagues within the RCPCH and with the RCGP.

You have asked us to:

- consider the facts of the case
- form a view on whether educational messages on 'rare causes of common symptoms' should be circulated to our members
- form a view on whether the algorithms generated by the 111 service need further modification to prevent a future death of this kind.

The RCPCH is a professional membership body responsible for training and examining paediatricians, setting professional standards and informing research and policy for children's health services and the paediatric workforce. Given that we do not have all the details of the investigation, the RCPCH is unable to comment on the specifics of the case.

In considering the information that we do have about this case, I am pleased to set out below the standards of care that we would expect from local service planning, and other work from the RCPCH where we feel a difference can be made.

Facing the Future – standards for paediatric care

Together for Child Health

These standards[1] apply across the unscheduled care pathway to improve healthcare and outcomes for children. They focus on the acutely mild to moderately unwell child and were jointly developed with the Royal College of Nursing and Royal College of General Practitioners.

The overarching principles agreed when developing this work that are relevant to the context surrounding this child's passing are as follows:

- every child should have timely access to high-quality unscheduled care services that are safe, effective and caring, that promote good health and wellbeing and that reduce the impact of illness on the child and their parents and carers
- service providers, planners and commissioners to work together across hospital and community services, primary and secondary care and paediatrics and general practice to design and deliver efficient and effective unscheduled care in a geographical network which is responsive to the needs of local children and their parents and carers.

[1] https://www.rcpch.ac.uk/resources/facing-future-together-child-health

A summary of standards that we feel are most relevant to ensuring children receive safe and timely unscheduled care include:

- GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.
- Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.
- Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.
- Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.
- There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

We have collected some best practice examples[2] on our website to share and encourage innovation across local service planning and delivery. We anticipate local discussions around urgent care pathways to gather momentum as the Health and Care Act in England has formalised the creating of Integrated Care Boards (ICB). The creation of an executive children's lead on each ICB will provide leadership and accountability for the important service issues in child health.

Standards for children and young people in emergency settings

These standards[3] aim to ensure that urgent and emergency care is fully integrated to ensure children are seen by the right people, at the right place and in the right setting. As the standards document describes, the future of urgent and emergency care for children is dependent upon building whole system networks that harness expertise within the subspecialty of paediatric emergency medicine that links across all urgent care and community settings.

Developing robust care pathways, building capability amongst professionals (such as GPs, health visitors, pharmacists and paramedics), and providing seamless links via intuitive governance and information sharing platforms will enable children to be managed by the right person, in the right place, at the right time and as close to home as is possible and safe to do so.

Paediatric Early Warning System and safety netting

We are collaborating with NHS England and the Royal College of Nursing to develop a single nationally validated Paediatric Early Warning score and system, (PEWS) for England. In 2020, the NHS SPOT (System-wide Paediatric Observations Tracking) Programme was launched.

A standardised paediatric early warning chart that records regular observations and highlights parameters for early escalation in acute hospital settings is currently being actively tested in several pilot Trust sites. There are future plans to extend an adapted framework of the acute charts to ambulance, NHS111 and primary care settings as part of a wider NHSE SPOT Programme led by the NHSE CYP Transformation Team.

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[2] https://www.rcpch.ac.uk/resources/facing-future-best-practice-examples
[3] https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings

The RCPCH hosts patient safety resources for its members and other health professionals via dedicated sections on the main RCPCH website and its focused microsite 'QI Central'[4], with quality improvement projects and open access educational resources in patient safety across a breadth of topics including clinical governance, situation awareness, patient-centred care, human factors and early detection of deterioration. A dedicated Patient Safety microsite and educational podcast series is currently in development for projected launch in 2023.

We also signpost members to online learning resources to help paediatricians with 'Spotting the Sick Child'. This contains over five hours of clinical footage of real patients, with learning pointers to help users focus on key themes. The user will learn how to assess seven common symptoms, which includes abdominal pain.

111 algorithms

It was useful to hear about the change to the 111 algorithms as a result of learning from the circumstances surrounding Esma's passing. The pathways used to inform 111 are currently developed and managed by NHS Digital to the NHS in England and to individual users, including but not limited to NHS Pathways and 111online.nhs.uk. The RCPCH are not required to and do not endorse these pathways but paediatricians represent the RCPCH to provide clinical advice and expertise to inform their shaping and to provide clinical expertise on ad hoc queries and patient safety concerns.

The RCPCH will take up further discussions with NHS Pathways to understand the changes made to these algorithms and to consider whether future work is needed to ensure all children who are deteriorating are referred to the appropriate acute paediatric health setting. The Academy of Medical Royal Colleges are in active discussion with NHS Digital about future arrangements for national clinical assurance of pathways that reflects the most up to date guidance and expertise. The RCPCH will be supporting the Academy by providing paediatric subject matter expertise to the clinical assurance workstreams.

Separately, during the pandemic, the RCPCH supported the NHS 111 service by encouraging paediatricians who were shielding or not able to work in health settings for any reason to work in core NHS 111 centres to help manage the burden of high volume calls at that time. The NHS England CYP Transformation Team evaluated this pilot to understand feasibility of including paediatric expertise within NHS 111, and its impact on service delivery. The data showed that enhanced paediatric support within NHS 111 CAS is likely to reduce the large volume of children advised to attend ED or primary care, while improving the families' experience.[5]

Next steps

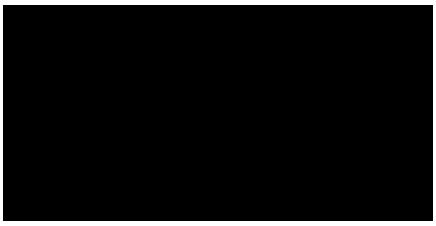
Thank you for reminding us of the importance of this work. Your report will be shared further with our Quality in Clinical Practice committee for further discussion this Autumn, and any further opportunities that the RCPCH identify to ensure a death of this kind is prevented in the future will be established and taken forward at this committee.

We will also continue to collaborate and support our colleagues at the Royal College of General Practice on promoting safe and effective pathways of care for children and young people. We are committed to carrying out the actions needed to ensure standards of care are maintained and the

[4] https://qicentral.rcpch.ac.uk/
[5] https://adc.bmj.com/content/106/Suppl_1/A372.1

child health workforce more broadly is represented in national discussions on children's urgent and emergency healthcare, and patient safety.

Yours sincerely,



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President
Royal College of Paediatrics and Child Health