Witness Name: Dr
Camilla Kingdon,
RCPCH
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated:

THIRLWALL INQUIRY

WITNESS STATEMENT OF ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH

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1. I, Dr Camilla Kingdon, am the President of Royal College of Paediatrics and Child Health (RCPCH). I was elected in May 2021 and my term will finish in March 2024. I was the RCPCH Vice President for Education and Professional Development from July 2018 to May 2021. In 2015-16 I was a member of the Heads of Schools Committee and Careers Advisory Group.

2. I am providing this statement to the Thirlwall Inquiry to answer part C of the Inquiry's terms of reference, and this witness statement should be read alongside the corporate statement filed on 8 February 2024 which addresses the issues raised by Section B of the Inquiry's terms of reference. I make this witness statement on behalf of the RCPCH as its President.

Background

3. I completed my undergraduate medical studies in South Africa and came to London in 1991 where I undertook some other hospital roles before starting to work in paediatrics in 1992. I became a consultant paediatrician in 2000. I have had a longstanding involvement in medical education, as I was head of the London School of Paediatrics and Child Health, which meant that I was responsible for training over 1,000 postgraduate trainees in paediatrics across 32 provider trusts throughout the London area from 2014 to 2018 and so had a chance to see a range of paediatric work in differing clinical settings. I also

completed a Masters in Medical Careers Management in 2013 and led the RCPCH careers advisors networks, and so have undertaken work assessing the working lives of paediatricians and their morale.

4. My clinical speciality is neonatology and I have worked in this area for Guy's and St. Thomas's NHS Foundation Trust (Evelina London Children's Hospital) since 2000. My specialist interests in practice are neonatal nutrition and donor milk banking. I setup the donor milk bank at St. Thomas's in 2005. I lead the follow up programme for high-risk neonates at my trust.

5. The RCPCH is a charity established by Royal Charter in 1996. Its charitable objectives, as set out in Clause 3 of its Royal Charter, (RCPCH/0544 **INQ0010246**) are:

   i) *To advance the art and science of paediatrics*
   ii) *To raise the standard of medical care provided to children*
   iii) *To educate and examine those concerned with the health of children*
   iv) *To advance the education of the public (and in particular medical practitioners) in child health, which means the protection of children, the prevention of illness and disease in children and safeguarding their optimal development.*

6. As of 2024, RCPCH has over 22,000 members, all of whom are child health professionals – almost all paediatricians. About 75% of RCPCH members are based in the UK and the rest internationally. Although RCPCH welcomes members from other professional groups (such as nurses and social workers) in its Affiliate category (approximately 355) (RCPCH/0545 **INQ0010247**), it is in no sense a representative body for, say, paediatric or neonatal nurses in the same way as it is for paediatricians.

7. As President, I am elected by the RCPCH membership and represent that membership. I make this statement on behalf of the members of the RCPCH.

8. This statement has been developed with input from RCPCH Officers including the Registrar, Assistant Registrar, Vice President for Health Policy, Officer for Health Services and Officers for Clinical Standards and Quality Improvement. RCPCH Officers are working paediatricians and provide leadership and strategic direction to drive forward College activity from committees that are established to generate insights from members, stakeholders and other experts. Using these insights, College Officers develop and offer opinion and advice on policy, professional practice, and models of care in relation to health policy. Officers hold a distinct role in providing this expertise, separate to staff.

Governance and management structures

9. The inquiry has asked the RCPCH about the effectiveness of hospital governance and management structures in keeping children safe and ensuring a good quality of care. The RCPCH as a membership organisation reflects the views of its members who undertake frontline work in paediatric care across the UK, and globally. The mechanisms which exist to oversee the safety of patients and the quality of care are complex and involves not just hospital governance and management, but also a number of additional external bodies. The system of oversight both within hospitals and for external bodies is overlapping and, in the RCPCH's view, sometimes lacking coherence and clarity.

10. In respect of hospital governance and management, the RCPCH consider that the structures in place are more focussed on reacting to concerns raised through incident reporting, than proactively creating and supporting a culture, system and process that prevent harm and ensure quality of care.

11. I understand that the Inquiry has surveyed hospital organisations providing neonatal care across the country and will be building evidence to understand the various approaches taken to ensuring there are arrangements for reporting and acting on concerns. There is no standardised national mandate on '<u>how</u>' to ensure that effective hospital governance or management structures are in place to prevent harm. However, the Care Quality

Commission can request healthcare providers to provide a written report setting out how they assess, monitor, and where required, improve the quality and safety of their services via regulation 17 on good governance. The Inquiry may wish to explore existing frameworks for assessing the quality of governance and management structures as factors to ensuring safety and quality (RCPCH/0557 and RCPCH/0558 **INQ0012273 and INQ0012274**), examples of which describe behaviours that may help Boards focus on improving quality and show how different leadership approaches may contribute to delivering major system change.

12. Whilst each hospital organisation is likely to have the appropriate governance in place 'on paper' to support patient safety and quality of care, there are five elements that the RCPCH consider must be in place 'in practice' on a consistent basis to be able to meet these aims. These are in addition to the requirements for all healthcare professionals to be accredited and regulated to provide good and safe care.

    a) Resource
    b) Appropriate data and metrics
    c) An established safety culture ensuring that everyone working in the NHS feels safe and confident to speak up
    d) Appropriate lines of accountability up to Board level
    e) Timely response and action when concerns are raised.

13. It is the view of the RCPCH that there are challenges with promoting and maintaining each of these elements, as explained below.

Resource

14. Providing healthcare services for children in hospitals which are safe and of a consistently high quality, requires timely decision making at Board level to ensure that appropriate resources are made available, both in respect of adequate levels of financial resources and also adequate personnel. This requires safe and effective care pathways, clinical environments, and

adequate staffing. The RCPCH is aware that hospital services for children are under immense financial pressure and have limited resource to cope and respond well to rising demand (for example, over 400,000 children were waiting for treatment in May 2023) (RCPCH/0587 **INQ0012295**). There is some commentary to suggest that the pressure on health services is prohibiting progress with the introduction and implementation of patient safety systems across the NHS (RCPCH/0569 **INQ0012285**). Without the relevant clinical staff in place in sufficient numbers alongside sufficient space for them to work and treat patients safety is compromised.

15. Healthcare is often complex, unpredictable and requires a flexible healthcare system and workforce to manage uncertainty and to adapt to change quickly. Neonatology is a particular example of where rapid advancements in care, as well as changing public expectations about where the limits of viability are (as an example), mean that services are required to enlarge or change often very quickly. Whilst healthcare professionals do their best to be resilient in this ever-changing system, it can be challenging to deliver safe, effective and quality care in an NHS that is financially limited. RCPCH members generally agree that hospital management are supportive of patient safety initiatives and will support clinicians to escalate concerns about safety. However, it is more difficult to secure management support if there is a financial implication associated with taking forward an action to prevent harm or respond to a patient safety concern for example, making changes to the clinical environment or recruiting additional staff.

16. As a result of national and local policy decisions that focus predominantly on adult care, it is the RCPCH's view that there is a lack of priority for children's services and their health outcomes. The Department for Health and Social Care's Major Conditions Strategy first published in 2023 was starkly focused on adult care, and the priorities set out in NHS England's 2023 annual operational planning guidance focused mostly on how the system should deliver for adults (RCPCH/0584 **INQ0012292**). Given that the performance of hospital leadership will be examined against the national performance imperatives and policy guidance, it is not surprising that children's services

are not viewed as a priority if they are not reflected and recognised in the strategies which NHS England and hospitals are asked to implement.

17. Paediatric and children's services make up only a small part of the overall provision of healthcare in most hospitals. It is all too easy for this to be given less priority, even if unintentional, in a system where resources are stretched. The allocation of monies given in hospitals to care for babies and children can often be significantly less than the demand for such care and the levels of need. The RCPCH considers that current demands from the rising volume and complexity of health needs of children already exceeds the workforce in place to provide care, and future demands on children's services is likely to increase further as children are surviving with more medical complexity from advances in medicines and treatments.

18. Furthermore, the RCPCH observes that in general, the focus in hospitals and central decision making, and prioritisation by NHS England and government, is on adult-focused indicators, such as cancer care waiting time standards, predominantly higher-volume low complexity elective care for adults, and waiting times in A&E. This therefore means that children are not the priority at Board level with regards to decision-making around finance and investment, as it is not seen as a priority against which Trusts and their boards are judged.

19. This lack of financial resource for children's services often results in significant workforce constraints, risking poorer quality of care. The RCPCH described this in its most recent National Neonatal Audit Programme (NNAP) report 2022, identifying that "*The continuing decline in neonatal nurse staffing levels is a matter of serious concern to those providing and commissioning neonatal services, given its association with increased mortality*" (RCPCH/0585 **INQ0012293**). The NHS Long Term Workforce Plan made no commitment to investing in growing children's nurses, compared with an almost doubling of adult nursing training places by 2031. The Inquiry may want to obtain information from NHS Resolution to understand the financial cost of clinical negligence claims in maternity care and children's

health services and compare this with the limited investment and priority that children's services are given.

20. In 2021, the RCPCH wrote to the Department of Health and Social Care and NHS England to ask for ring-fenced funding to meet a number of safety and quality needs in neonatal units, including more resource to analyse data and the appointment of a Neonatal Safety Champion (RCPCH/0574 **INQ0012290**). The Inquiry may want to explore with the Department of Health and Social Care and NHS England whether these priority areas to improve safety will be considered and implemented.

Appropriate data and metrics

21. Each hospital organisation is mandated to provide the NHS with information that includes but is not limited to the occurrence of 'never events', serious incidents and events relating to the safety of employees, such as, for example, accidental or unintended exposure to ionising radiation. 'Never events' (RCPCH/0588 **INQ0012296**) are patient safety incidents that are preventable and so serious they should never happen. An incident is serious if it causes or could cause harm to an individual, a group, or the public. These data focus on measuring past harm, and the Inquiry may want to work with NHS Providers, NIHR Patient Safety Research Collaborations (RCPCH/0559 **INQ0012275**) and other health organisations to understand more about what data and metrics may be helpful to consider NHS safety in the present and future. Information to test improvements to an organisation's safety culture could be especially valuable to preventing future harm and the Inquiry may wish to look to the Manchester Patient Safety Framework (MaPSaF) as an example of a tool that helps health organisations understand what a more mature safety culture may look like and evaluate what actions may be needed to change their own culture in this respect (RCPCH/0560 **INQ0012276**).

22. The RCPCH has concerns that data flow between maternity and neonatal systems is inadequate. Clinical information collected in maternity settings is

often not transferred or made available in neonatal care. It is important that patient safety and outcome data across both maternity and neonatal services is appropriately linked to ensure future systems can identify and respond to areas of risk.

23. There are 2 national audit programmes which are relevant to this area. The National Neonatal Audit Programme (NNAP) is organised by the RCPCH. The National Maternity and Perinatal Audit (NMPA) is led by the Royal College of Obstetricians and Gynaecologists in partnership with the Royal College of Midwives, the RCPCH and the London School of Hygiene and Tropical Medicine. NNAP and NMPA has developed a joint proposal linking neonatal and maternity datasets, which would allow the reporting of the neonatal outcomes of maternity care. The proposal is supported by Healthcare Quality Improvement Partnership (HQIP) and NHS England, as well as the wider neonatal community. NNAP is a mature audit tool, with significant clinician buy-in. The NMPA is yet to reach its potential but could be the source of rapid and reliable data. If NHS organisations prioritise linking the two data sets, there will be opportunities to understand where care can be improved in both maternity and neonatal services.

24. The Perinatal Mortality Review Tool (PMRT) has been in place since early 2018 and is an important national tool for understanding in detail, every single stillbirth and neonatal death. Both PMRT and NNAP, in my view, are the two most important tools available to scrutinise deaths and identify trends. PMRT currently reports annually, which could be considered when looking at the availability and timeliness of data.

An established safety culture ensuring that everyone working in the NHS feels safe and confident to speak up

25. An absence of, or resistance to implementing a culture of safety has been a key and recurring theme in reports where there has been poor care. NHS England describes a positive safety culture *"as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual*

staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care". This includes but is not limited to ensuring psychological safety for everyone working in the health service, recognising the importance of listening to families and their concerns, and also listening to clinicians so that everyone in the NHS feels safe and confident to speak up. The RCPCH has concerns that patient safety policies are not being implemented effectively because safety culture is not always embedded in hospitals.

26. The British Association of Perinatal Medicine (BAPM) has developed guidance to support service leaders and healthcare professionals to understand and evaluate its culture in neonatal care (RCPCH/0566 **INQ0012282**). Whilst there are NHS services designed to support learning from patient safety events (RCPCH/0567 **INQ0012283**), front line healthcare staff could be made more aware of these tools. The RCPCH has been supporting BAPM with a call to the Department of Health and Social Care for the appointment of a national Neonatal Safety Champion to work alongside the champions for obstetrics and midwifery (RCPCH/0574 **INQ0012290**). The Parliamentary Under Secretary of State for Primary Care at the time, Maria Caulfield, asked officials to consider appointing a National Neonatal Safety Champion but no update on progress has been received since that correspondence in October 2021. The Inquiry may wish to receive an update on this from the Department of Health and Social Care.

27. It is worth noting that as part of the General Medical Council's (GMC) Good Medical Practice, staff from all clinical disciplines should have encouragement and protected time to attend training for example on morbidity/mortality and to undertake audit quality improvement projects.

Appropriate lines of accountability up to Board level

28. RCPCH members report through our governance structures that they are confident using existing mechanisms to escalate safety and risk concerns within paediatric departments. There is less clarity in many cases about where

and how risk is managed beyond the paediatric department, and the reporting responsibilities to Board level.

29. The RCPCH has long advocated for a children's lead at the highest level of every NHS organisation (RCPCH/0568 **INQ0012284**). At present, there is not sufficient evidence to understand whether this role has a bearing on patient safety or would do so. However, the Health and Social Care Act 2022 states that every Integrated Care Board (ICB) must identify members of its board to have explicit responsibility for a variety of population groups, including an executive lead for children and young people. Statutory guidance sets out that the executive lead for children and young people should have a line of sight for the delivery of all children and young people commitments led by the ICB and should provide visible and effective board-level leadership to address issues experienced by children and young people. It may be that the Department of Health and Social Care could instruct NHS England to appoint similar executive lead roles in Trust Boards to ensure there is appropriate oversight and resource allocated to children's services, so that children's health outcomes and needs have a distinct focus.

Timely response and action when concerns are raised.

30. There is rarely communication back to the paediatric department to describe the actions agreed to address safety and risk issues, including the proposed timelines to discharge those actions. It is likely that safety and risk issues in children's services are of smaller volume than other adult departments and it is possible that higher-volume issues, such as falls and bed sores, generate more focus. The lack of response to the paediatric department can therefore undermine confidence as to whether actions are being taken to ensure safety and quality of care. I am not aware of any standards or national mandate to ensure concerns that are raised around patient safety and quality are responded to in a timely and proportionate manner. Whilst members felt comfortable with the processes for escalating concerns from a particular unit or service, it can be unclear who is responsible for responding to that concern and implementing appropriate improvements, and in which

timeframe. The Inquiry may want to consider whether national standards or a mandate is required to provide consistency around accountability and timeliness to respond to patient safety and quality concerns across NHS services. This could include concerns from patients, healthcare professionals and NHS staff.

Professional regulation

31. There are currently nine regulators covering different groups of healthcare professionals within the NHS. The fragmentation and potential overlap across regulatory organisations for different professional groups and the different escalation routes for different professional groups within organisations can cause confusion and can also cause challenges with improving patient safety processes and quality of care for hospital organisations.

32. Structural reform over time with an ever-evolving NHS means many more regulatory bodies have been introduced, and some research has shown that as many as 126 organisations exert some regulatory influence in NHS provider organisations (RCPCH/0573 **INQ0012289**). The Inquiry may want to explore with the various health regulators and potentially NHS Providers, whether there is potential benefit to harmonising the various standards of regulation so that every professional group within the NHS is striving towards the same standard of good, safe care.

33. Given that the number of regulatory organisations has increased over time, and there remain uncommon but extremely serious instances of patient safety issues within the NHS, the Inquiry may want to explore with the health regulators whether they have the necessary remit and power to play a role to improving quality of care and patient safety and what further remit they may require.

Regulation of senior managers

34. The RCPCH has supported the proposal of formal regulation of NHS managers in its response to the Inquiry into Hyponatraemia-related Deaths (RCPCH/0571 **INQ0012287**), following the deaths of five children in hospitals in Northern Ireland. This was based on recommendations from Lord Francis in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry that sought to bring in NHS managers to adhere to the 'Seven Principles of Public Life', which includes selflessness, integrity, objectivity, accountability, openness, honesty and leadership (RCPCH/0572 **INQ0012288**).

35. The Inquiry may look to NHS Providers and NHS Confederation for better assistance with this question. It may be that regulation of these non-clinical professional groups is needed, but it may also be the case that it is not regulatory oversight, but clarity as to what they are accountable for and how they would support improvements to quality and patient safety.

Press Statements

36. Exhibits RCPCH/0575 to RCPCH/0581 **INQ0012265 to INQ0012271** document the RCPCH's public statements regarding the CoCH and the trial of Lucy Letby.

Statement of Truth

37. I believe that the facts stated in this witness statement are true. i understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed: ______________________

Dated: ________25th March 2024_______