



PAEDIATRICS

A NATIONAL MODEL OF CARE FOR PAEDIATRIC HEALTHCARE SERVICES IN IRELAND

CHAPTER 7: GOVERNANCE



Féidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Strategy and Programmes Division



**ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND**

The National Clinical Programme for Paediatrics and Neonatology adopts the clinical governance structures set out in 'The Code of Governance Framework for the Corporate and Financial Governance of the Health Service Executive Version 4, 2011' and 'National Clinical Programmes Model of Care Development Checklist Governance for Quality and Safety 2014'.

Paediatric and neonatology services are provided in varying locations:

- paediatric and neonatology units in regional and local hospitals,
- stand-alone tertiary paediatric hospitals,
- neonatology units in maternity hospitals.

Regardless of the setting, effective governance arrangements should recognise the interdependencies between corporate, financial and clinical governance across the service and integrate them to deliver high quality, safe and reliable healthcare.

The National Clinical Programmes Model of Care Development Checklist Governance for Quality and Safety (2014) documentation states that clinical governance is the system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they have delivered. This means specifying the clinical standards to be delivered and demonstrating the measurements that have been made to show outcomes.

Each individual working on a team in paediatric and neonatal services should:

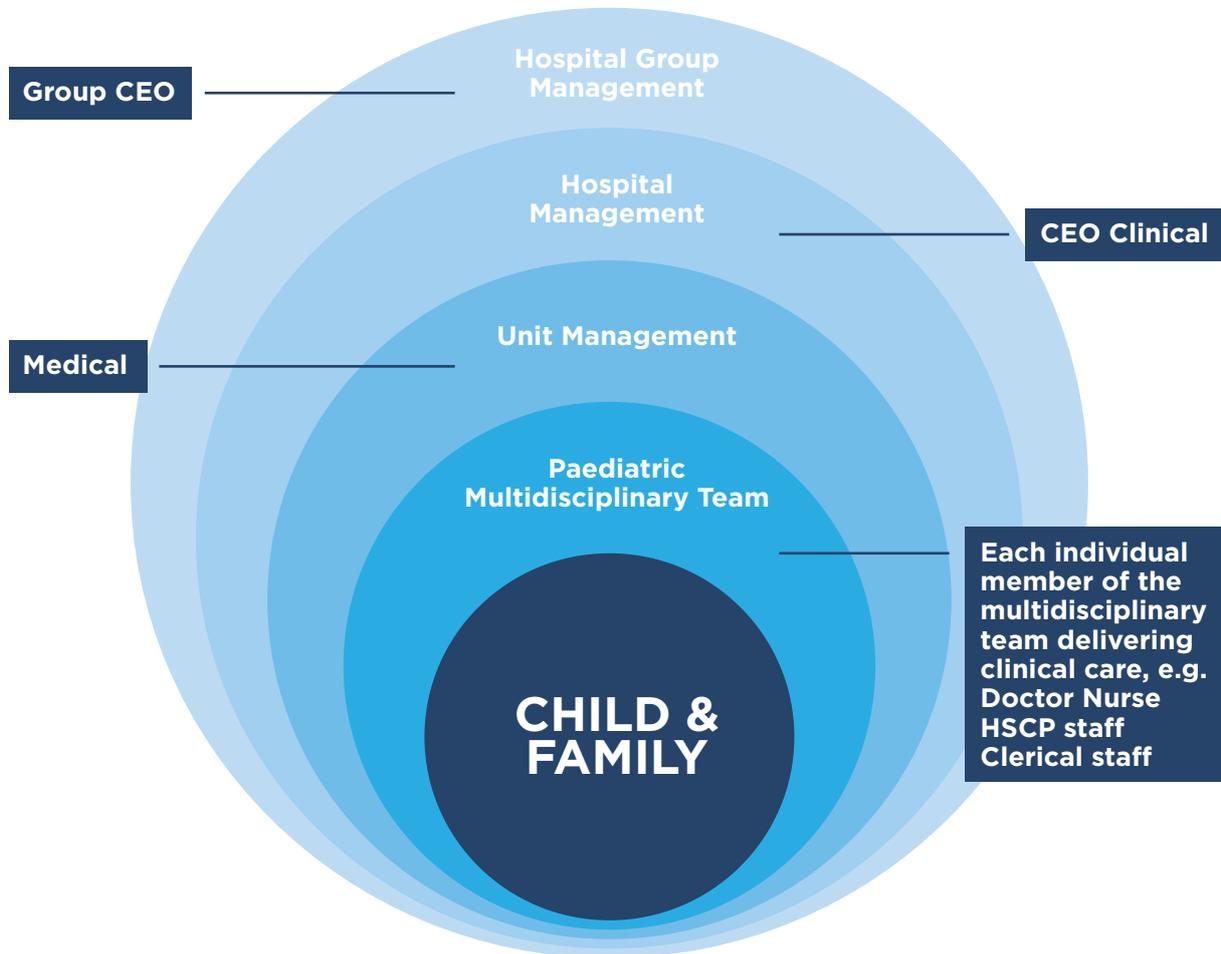
- know the purpose and function of leadership and accountability for good clinical and social care;
- know their responsibility, level of authority and who they are accountable to;
- understand how the principles of clinical governance can be applied in their diverse practice;
- consistently demonstrate a commitment to the principles of clinical governance in decision making.

The National Clinical Programme for Paediatrics and Neonatology document 'Review of Paediatric and Neonatology Services and Framework for Future Development' (2013) made a number of specific recommendations in relation to clinical governance, namely;

1. Formal clinical governance structures should be adopted in each paediatric centre including the collection and regular reporting (locally and nationally) of clinical data, performance management, managing risk, reporting, managing and learning from adverse events and participation in clinical audit.
2. Regional centres should develop networks with neighbouring hospitals (based on the development of hospital groups).
3. All departments should hold monthly meetings with formal written minutes with quality and safety as a standing agenda item.
4. Services should support a person-centred approach, include service-user participation and seek regular feedback from children and families on their experience of the service.
5. Accountability for the services delivered should be defined, i.e. who is responsible and what are they responsible for.

The roles and responsibilities of individuals working in paediatric and neonatology teams are described throughout this model of care. It is recommended that each unit has a medical director and director of nursing.

Suggested Governance for Quality and Safety of a Paediatric Unit in a Local / Regional Hospital



Quality and Safety

Quality improvement and safety incorporates accountability for clinical performance. The aim is to create and support an environment in which all staff understand their role within the service, recognise their accountability and are committed to the guiding principles for quality and safety.

Paediatric and neonatology teams should operate in culture of trust, openness, respect, caring where achievements are recognised. Open discussion of adverse events should be embedded in everyday practice and communicated openly to patients. Staff should willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care. All units should have regular, minuted departmental meetings and publish annual reports. Issues raised at departmental level should include quality of care, manpower and staffing issues, unit activity statistics, infection rates, equipment, training and development, research and audit. Deficiencies or concerns should be channelled to the appropriate hospital executive for further action.

In the event of a critical incident occurring, a statutory reporting obligation arises using the HSE Safety Incident Management Policy 2014 and / or the HSE Good Faith Reporting Policy 2011. In addition, should a critical incident occur, an open disclosure procedure arises according to the HSE and State Claims Agency Open Disclosure National Policy 2013.

Each multidisciplinary team (MDT) should follow national HSE policies, protocols and guidelines, including those developed by the National Clinical Programme for Paediatrics and Neonatology. MDTs should also have hospital group and / or department policies in place.

The National Clinical Programme for Paediatrics and Neonatology is committed to risk management and patient safety. Teams working within paediatric services are required to adhere to the HSE risk management handbook and the processes contained within.

Clinical audit is recognised as a means of proactively measuring the effectiveness and performance of healthcare against agreed standards for high quality. It provides a method for improving the quality of care provided to service users by identifying action to bring practice in line with these standards. It provides the assurance of quality to service users, practitioners and to the health system as a whole. The National Clinical Programme for Paediatrics and Neonatology recommends that every paediatric and neonatology unit engages in clinical audit to review and evaluate practice.

The National Clinical Programme for Paediatrics and Neonatology recommends the identification of quality-of-clinical-care indicators for paediatric and neonatology services. The indicators should be monitored at the monthly team meetings and reports to the Quality and Safety Executive Committee through the relevant Directorate in the hospital / hospital group.