NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 14 August 2023**
Title:	**Quality and Safety Paediatric Work stream**
Responsible Director:	**Jennifer Wilson, Nurse Director**
Report Author:	**Attica Wheeler, Associate Nurse Director & Head of Midwifery – Women and Children's Services** **Jackie Welsh, Improvement Advisor – Women and Children's Services**

1. Purpose

This is presented to the Board for:

- Awareness

This paper relates to:

- Annual Operational Plan

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective

2. Report summary

2.1 Situation

This paper provides an overview of progress in relation to core Scottish Patient Safety Programme (SPSP) measures and also the Excellence in Care measures within the Paediatric programme.

2.2 Background

NHS Boards report regularly on SPSP performance measures to Healthcare Improvement Scotland (HIS) in order to enable Boards and the national programme team to understand overall progress in relation to the aims of SPSP and the national programme team to understand overall progress in relation to the aims of SPSP and EiC

MCQIC was launched in March 2013 and is a programme of quality improvement (QI). The MCQIC collaborative covers three work streams of Maternity, Neonatal and Paediatrics. This paper presents the paediatric improvement work.

As per the current joint Partnership agreement between NHS Ayrshire & Arran (NHSAA) and the SPSP MCQIC Team, the following four areas were agreed to focus on improvement:

- Reduce unplanned admissions to Paediatric Intensive Care Unit (PICU)
- Introduce and measure compliance with the national PEWS
- Implement and attain measures contained within the Watchers Bundle
- Improve Compliance with the Sepsis Six bundle

The Paediatric Early Warning Score measure comes under the auspice of SPSP and Excellence in Care. The national team have not supported the work on the paediatric programme for some time for a number of reasons, mainly redeployment of staff to support COVID-19 and staffing shortages (no Clinical Lead), which had a direct impact on the programme and support nationally. A clinical lead and an Improvement Advisor for paediatrics has now been appointed and a scoping exercise was carried out to identify priorities for Boards moving forward.

It was announced in March 2023, that MCQIC would be rebranded and the women and children's programme (MCQIC) would now be split into two programmes SPSP Perinatal (for Maternity and Neonatal), and SPSP Paediatrics. Expert Reference Groups (ERGs) for both these services have been set up with three staff members from each Board to identify and drive the programmes of work moving forward. The Paediatric ERG met for the first time on 29 March 2023. The three main areas identified for paediatrics are; RSV/Winter Viruses, Deteriorating Patient and Medicines Safety. The focus of this meeting was the driver diagram for deteriorating patient which has been circulated to management and the Paediatric QI Group members for consultation.

NHSAA have continued to measure compliance on existing measures and implement improvement where possible. Due to clinical pressures during the pandemic, this was not consistent and we reviewed our data collection process within Paediatrics. Pressures within the service continue to impact QI activity.

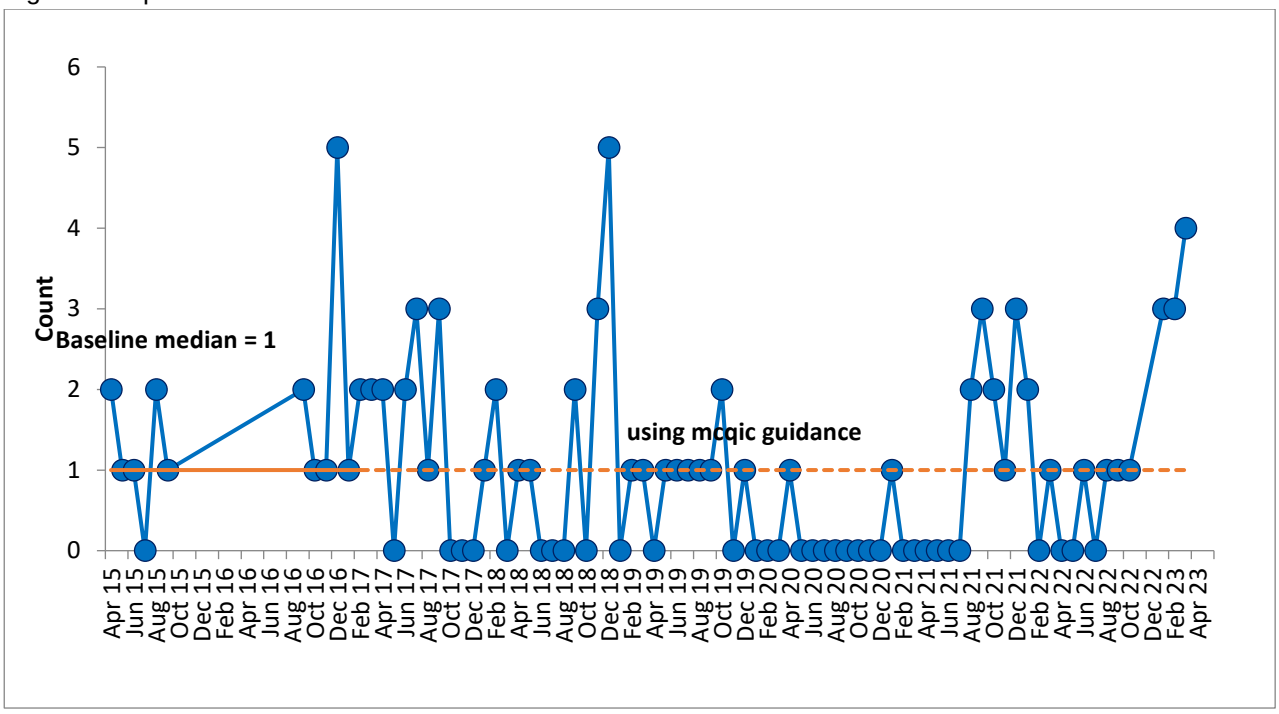
A QI Framework has been developed within Women and Children's services which will have a direct impact on all aspects of QI moving forward. This has been developed collaboratively with the Clinical Leads for QI and service QI Champions.

2.3 Assessment

Unplanned Admission to Paediatric Intensive Care Unit (PICU)

As demonstrated in **Figure 1** below, the number of unplanned admissions remain generally low. There have however been 14 instances in the past twelve months, averaging 1.1 per month. These have previously been attributed to respiratory illness and lack of access to GPs, wherein first line treatment had not been accessible, resulting in the children requiring further intensive care. There has been recent scrutiny of the data and it is believed that the numbers could be higher due to misinterpretation of the operational definition. There is a plan to explore this further and advice is awaited from Healthcare Improvement Scotland (HIS).

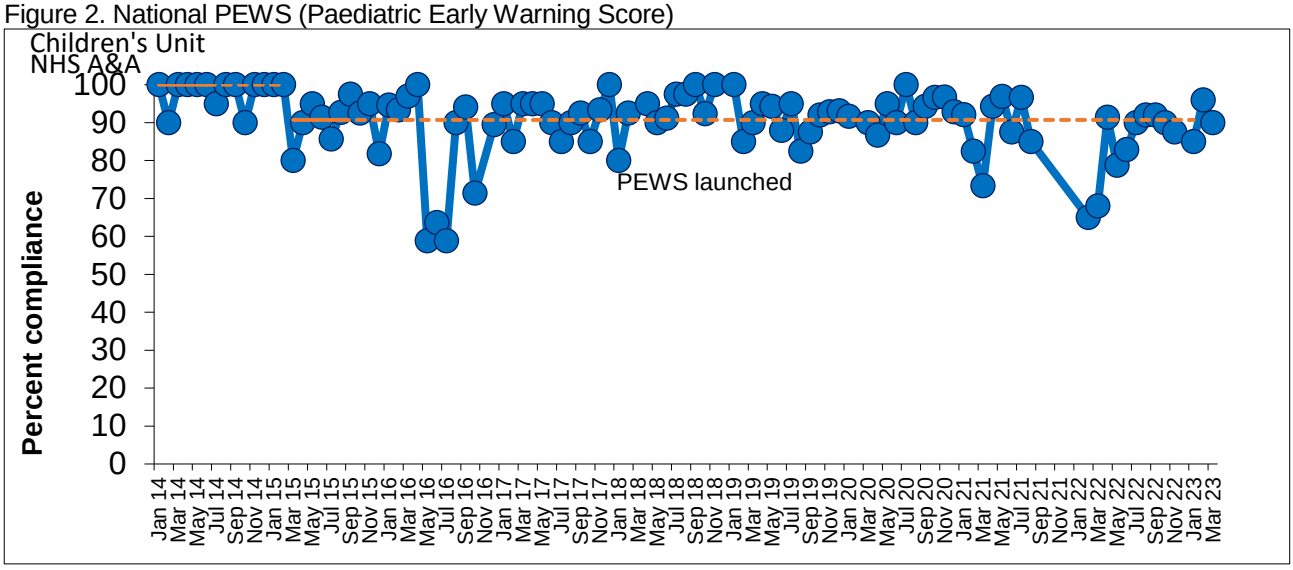
Figure 1 Unplanned Admission to PICU



Paediatric Early Warning Score (PEWS)

The national PEWS has been rolled out across Scotland. This allows consistency of reporting and understanding of information across the Paediatric service in Scotland and is of particular assistance locally when in discussion with colleagues regarding an individual's progress or deterioration. This data was not recorded from August 2021 to February 2022 due to the pressures on the ward due to Covid-19. Since March 2022 we have noted a steady increase in compliance. The chart below demonstrates compliance with the Pews Bundle.

Figure 2. National PEWS (Paediatric Early Warning Score)



Watchers

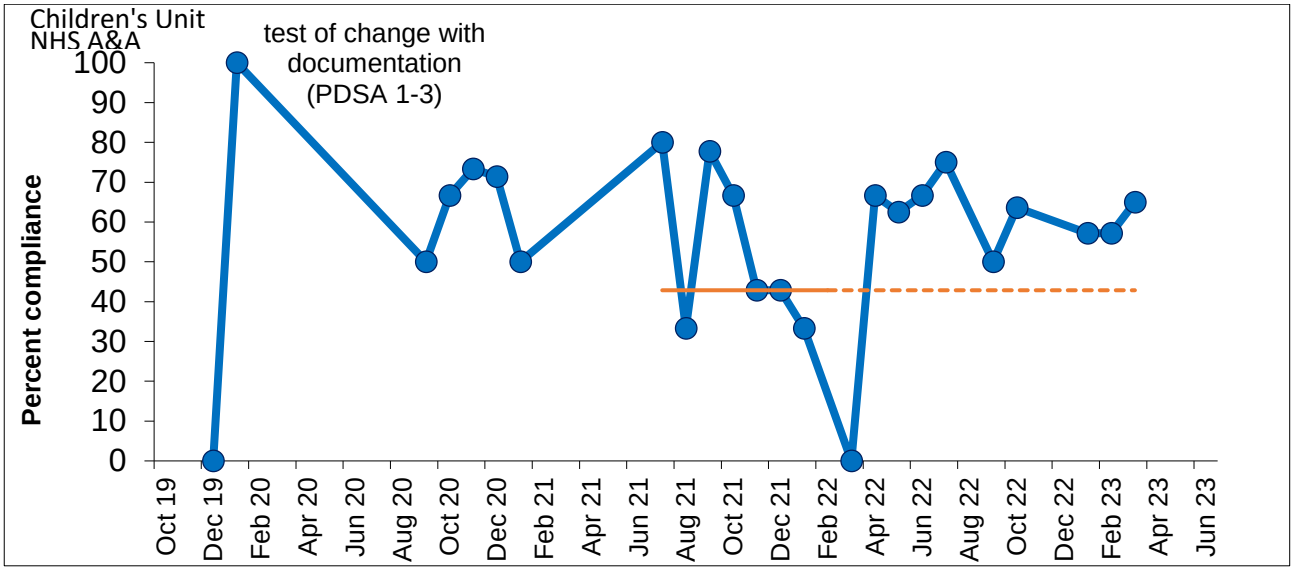
A 'Watcher' is a patient where there is an increased concern, including the following reasons:

- Children and young people we are worried about
- Children and young people with potential/anticipated deterioration
- Children and young people whose health are causing concern to staff and parents
- Children and young people whose family are worried about them

The watchers bundle was gaining momentum and through training and discussion at the safety brief, staff became familiar with this. The testing of the watchers bundle was suspended due to the Covid restrictions and the data is therefore sporadic. Since re-introducing the QI projects within the Unit, improvement in practice and recording of information can now be demonstrated. Our target is to ensure 100% compliance with this bundle.

Looking at the data in **Figure 3**, we note 9 points above the median line, which would indicate sustained improvement, however as there are gaps in the recording of the data we are unable to re-calculate the median line at this time.

Figure 3. Compliance with 'Watchers' Bundle

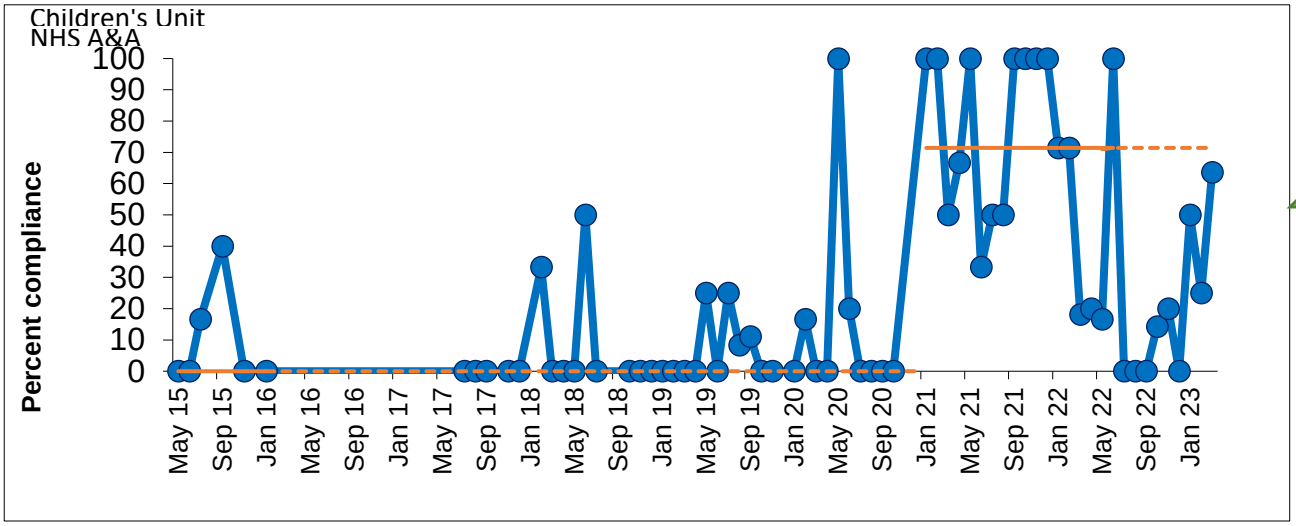


Sepsis

Compliance with the sepsis bundle has been challenging as there are certain elements of the bundle which are often not undertaken, in particular the 'consideration of Inotropes'. Usually by the time inotropes are being considered, the child is being transferred to PICU. We have previously been in discussion with the MCQIC team to question the feasibility of this element of the bundle and also to ascertain what current practice is in other Boards. This was discussed at the ERG meeting. In light of the Academy of Medical Royal Colleges (AMRC) report and the draft SIGN Guidance, Sepsis is being reviewed as a whole and our concerns are being taken into consideration.

Locally, we had begun to make some progress, by completing the measure on the QI Portal which gives us a degree of flexibility to address the cases which are not applicable. The department are currently testing a new sticker for use in the department.

Figure 4. Compliance with the Paediatric Sepsis Bundle



Where there are no observations (no cases) data is shown as 0%

At a glance, it would appear the data has only been collected to January 2023, however this is down to the layout of the national toolkit and the data is in fact collected to March 2023

2.3.1 Quality/patient care

The overall aim of the programme is to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies, children and families across all care settings in Scotland.

- Admissions to PICU are generally low despite the latest spike. We have recently scrutinised the data and feel that the numbers could be higher, due to misinterpretation of the national operational definition. We plan to look further into this and await further advice from HIS,
- We have observed a steady increase in the compliance with the PEWS bundle over the past twelve months
- We note a sustained improvement in the compliance of the Watchers bundle, however as there are gaps in the recording of the data we are unable to re-calculate the median line at this time. Watchers still remains a focus of priority and subject to continuous discussion with staff.
- Much work has been carried out in the Unit around psychological safety and the QI educational programme to help build on the improvement programme.
- A QI Framework has been developed collaboratively with the General Manager, Improvement Advisor and the QI Leads/Champion's which includes paediatric services.

2.3.2 Workforce

There has been challenges due to Covid-19/sickness absence. We are, however, fully committed to remobilising the QI agenda.

2.3.3 Financial

There may be financial implications identified as new National Standards of care are identified. This will be discussed as the programme progresses.

2.3.4 Risk assessment/management

Delivery of the programme is aimed at reducing harm within Women & Children's services. Non delivery of the programme could impact on the provision of a safe service and reputation of the organisation if timely effective implementation does not happen.

2.3.5 Equality and diversity, including health inequalities

By working towards compliance with each of the measures as agreed with the MCQIC Partnership, we aim to protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

No impact assessment has been completed as the operational definitions as outlined by the MCQIC programme set out the inclusion of the population to be included in any measurement and this is a national programme of work.

2.3.6 Other impacts

The delivery of the elements contained within the MCQIC programme, the SPSP programme and Excellence in Care will support the Boards commitment to safe, effective and person centred care.

The service aims to provide compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values, and result in the people using our services having a positive experience of care to get the outcome they expect.

We will protect and improve the health and wellbeing of the population and reduce inequalities, including through advocacy, prevention and anticipatory care.

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- A partnership agreement between MCQIC and NHS Ayrshire & Arran in relation to the way forward with new measurements was signed off and sent to all relevant parties on 21 December 2018.
- The work contained within this measurement is discussed at the bi-monthly meetings held by the Paediatric Quality Improvement Group. A programme of meetings have been set up for 2023.

2.3.8 Route to the meeting

The work detailed in this paper is discussed at the Paediatric Quality Improvement Group meeting and the Paediatric CG meeting.

A version of this paper was presented to the Healthcare Governance Committee on 6 June 2023

2.4 Recommendation

The Board is asked to note the quality improvement and safety activity in Paediatric Services as part of the SPSP Maternity and Children Quality Improvement Collaborative (MCQIC) programme and Excellence in Care.

3. List of appendices

Nil