NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 15 August 2022**
Title:	**Scottish Patient Safety Programme (SPSP) – Maternity & Children Quality Improvement Collaborative (MCQIC): 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:

- Discussion

This paper relates to:

- NHS Board/Integration Joint Board Strategy or Direction

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 within the Paediatric programme.

Board members are asked to note and discuss the quality improvement and safety activity in Paediatric Services underway as part of the Maternity and Children Quality Improvement Collaborative (MCQIC) 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.

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 joint Partnership agreement between NHS Ayrshire & Arran 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

Due to Covid19, the MCQIC Programme was suspended nationally to enable staff to be deployed where necessary. This had an impact on the improvement work and data collection within Women and Children's Services also. There have been many challenges with the recording of information over the past 12-18 months with staffing issues and subsequent pressures on the ward. A new model of collecting information is now being trialled in order to ensure it is not person dependant, and data is collected consistently.

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 has a direct impact on the programme and support nationally. They are now in a position to appoint a Clinical Lead and an Improvement Advisor for paediatrics and, at the beginning of the year, sent a scoping form to each Board to identify priorities for moving forward. A national Webinar was held in February 2022 and the three main areas identified were: RSV/winter viruses, Deteriorating Patient and Medicines Safety. It is not thought this will have an impact on the work we are currently doing.

MCQIC plan to re-launch summer/autumn 2022, meanwhile NHS Ayrshire & Arran (NHSAA) has continued to measure compliance on existing measures and implement improvement where possible. Due to clinical pressures during the pandemic, this was not consistent and is the reason why we reviewed our data collection process within Paediatrics.

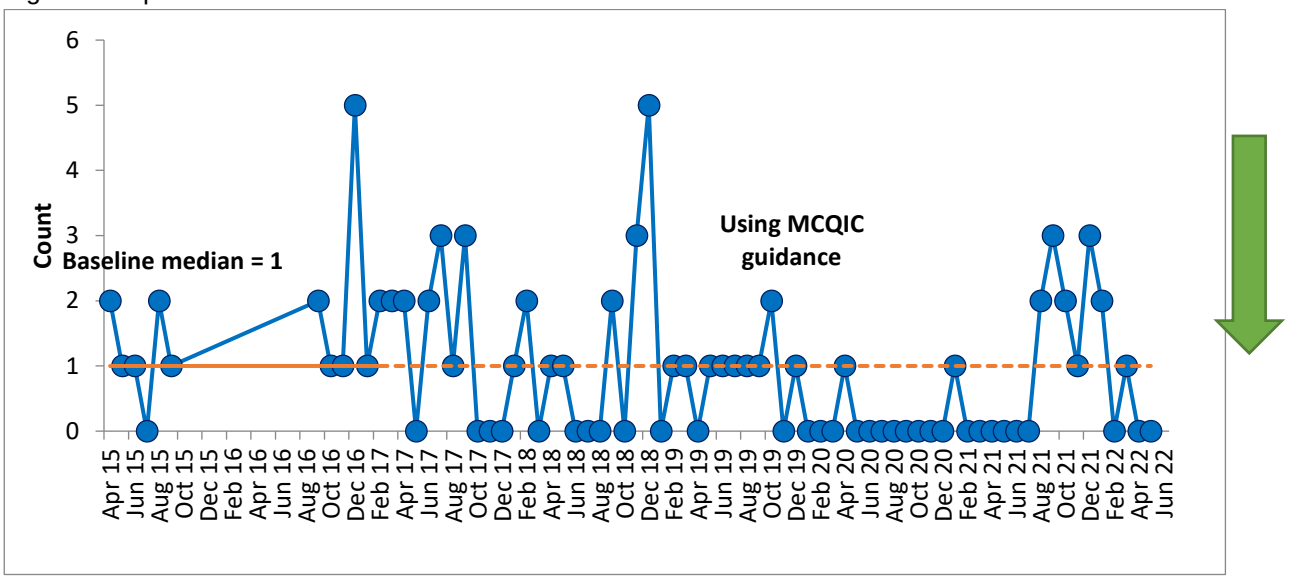
The General Manager is currently working with the Improvement Advisor to develop a QI Framework within Women and Children's services which will have a direct impact on all aspects of QI moving forward. This is being developed collaboratively with the Clinical Leads for QI and service QI Champion's.

2.3 Assessment

2.3.1 Unplanned Admission to Paediatric Intensive Care Unit (PICU)

The number of unplanned admissions remain generally low; however there have been 14 in the past twelve months, averaging 1.1 per month. These unplanned admissions have 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.

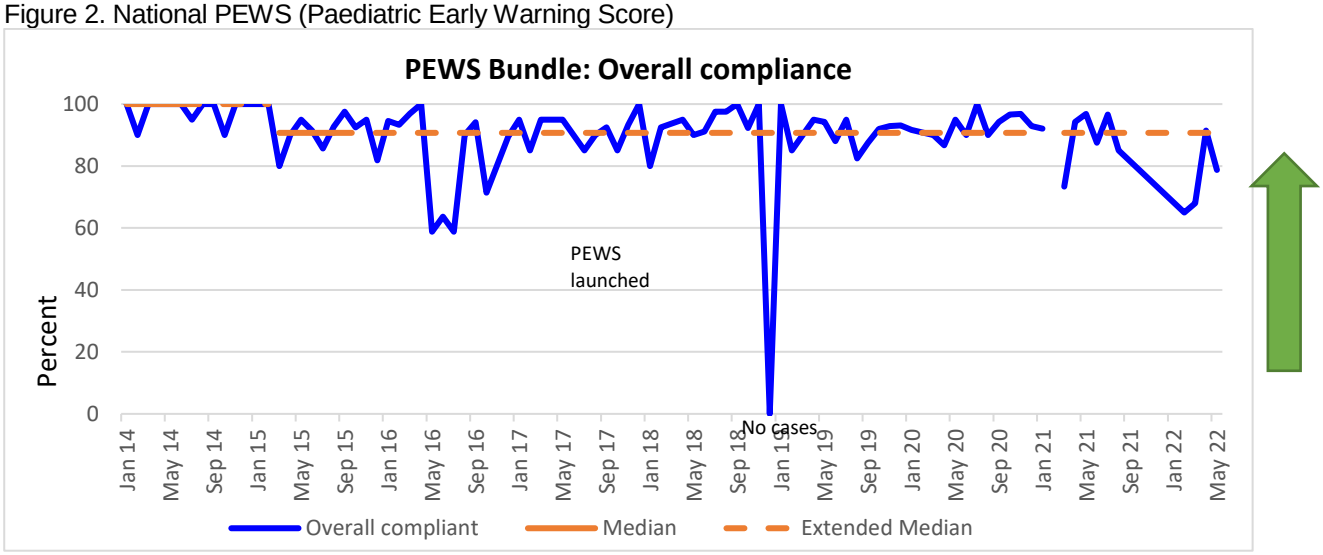
Figure 1 Unplanned Admission to PICU



2.3.2 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. We are currently reviewing staff training with regards to PEWS scoring and escalation as part of an LMTR learning summary. The chart below demonstrates compliance with the Pews Bundle.

Figure 2. National PEWS (Paediatric Early Warning Score)



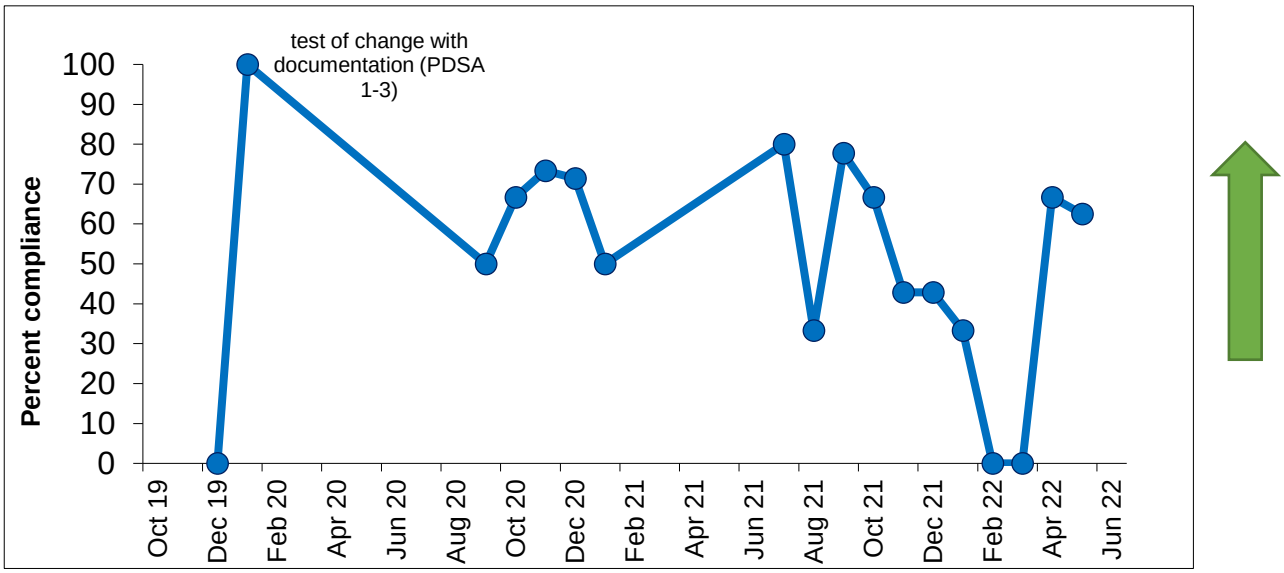
2.3.3 Watchers

A 'Watcher' is defined as a child who requires extra expert review 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 reintroducing the QI projects within the Unit, improvement in practice against recording of information can now be demonstrated. Our target is to ensure 100% compliance with this bundle.

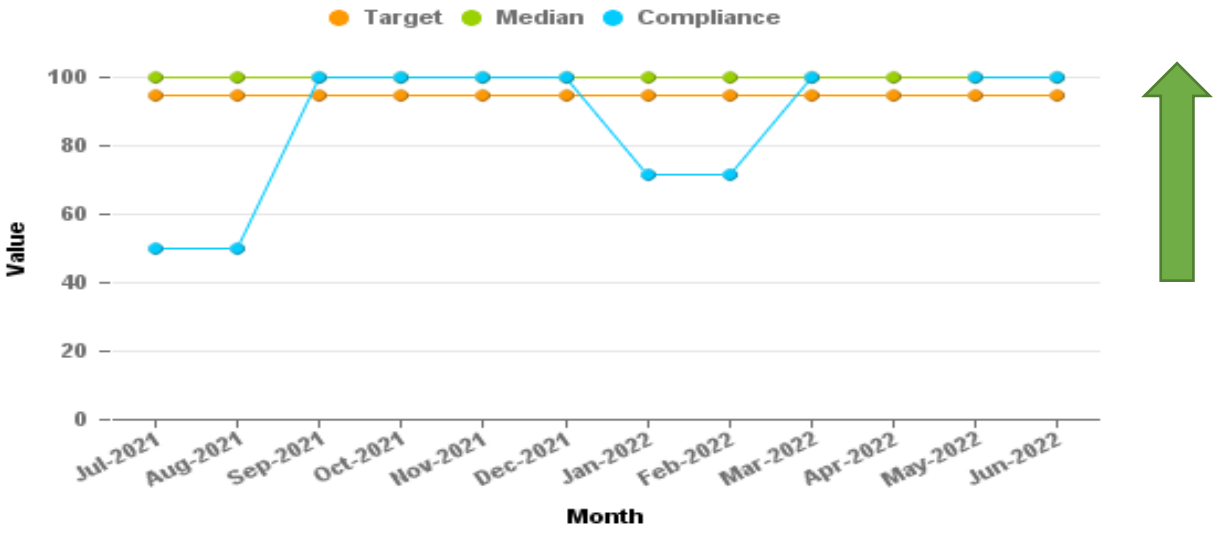
Figure 3. Compliance with 'Watchers' Bundle



2.3.4 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 been in discussion with the MCQIC team to question the feasibility of this element of the bundle and also to ascertain current practice in other Boards. 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.

Figure 4. Compliance with the Paediatric Sepsis Bundle



Throughout July the Children's Unit will be drawing awareness to Sepsis with teaching on Sepsis 6 bundle, Watchers and simulation training.

2.3.5 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 a recent spike, which we would attribute to the increase in children being admitted to the ward with respiratory illness.
- Compliance with the PEWS bundle remains varied. However, this is currently being addressed locally and new measures have been put in place.
- The watchers bundle is currently a focus within the Unit. Slippage has been identified and is being taken forward locally.
- 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 is being developed collaboratively with the General Manager, Improvement Advisor and the QI Leads/Champion's for the service.

2.3.6 Workforce

There has been a 20-30% deficit in staffing levels across the children's unit compared to pre-Covid levels. Staff (including the MCQIC Champion), have supported other clinical duties, which had an impact on ongoing improvement work/data submission. There has been a recruitment drive and we hope that by September the deficit will be minimised. Moving forward, emphasis will be placed on fully remobilising the QI agenda.

A Band 6 nurse has been seconded as an education facilitator. Their role will include teaching staff about the clinical theory behind why the QI indicators are so important. It is expected that this will have a positive impact on compliance within the unit.

2.3.7 Financial

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

2.3.8 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.

2.3.9 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.

2.3.10 Other impacts

The delivery of the elements contained within the MCQIC programme and the SPSP programme 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.

2.3.11 Communication, involvement, engagement and consultation

The service 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 monthly meetings held by the Paediatric Quality Improvement Group. These meetings were suspended due to COVID-19, however a programme of meetings has been set up to remobilise the Group and the first meeting was held in January 2022.

2.3.12 Route to the meeting

This paper has been discussed at senior management level in Women and Children's Services and is discussed at the Quality Improvement meeting and the Paediatric Clinical Governance meeting. A version of this paper was submitted to Healthcare Governance Committee on 6 June 2022.

2.4 Recommendation

For discussion. Board Members are asked to discuss the quality improvement and safety activity in Paediatric Services as part of the Maternity and Children Quality Improvement Collaborative (MCQIC) programme.