

Are We There Yet ?

NCEPOD – Surgery in Children

How Can We Get to Where we Wish to Be ?

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NCEPOD – UK Report

- **Welsh Health Service**
- Welsh Assembly Government Responsible for Health Budget
 - 3 million population
- **No Payment by Results**
- **Structure**
 - 7 Health Boards
 - Combined LHB and Hospital Trusts
 - Specialist Commissioner

The Task – “Put the report in the context of your speciality and comment on what impact you think it might have , or not !”

The Answer - “ To try and explore the means by which we can effect change for the remediable factors”

Dr Graham Shortland

Qualified - 1983 Soton (First Report 1989)

Consultant Paediatrician 1993 – to date

University Teaching Hospital Wales -

Paediatric Intensive Care Unit

Neonatology

General Paediatrics

Inherited Metabolic Disease

Medical Director June 2010 – to date

Cardiff and Vale UHB

14,000 staff

£1.1 billion budget

450 Consultants

What Needs to be Done?

Organisation of Care/Peer Review of Data;

Workload Recognition

Widespread Nature of Care

Transfers of Care/ Inter-Hospital Transfer

Management of the Sick Child

Clinical Governance and Audit

Individual Care;

Necrotising Enterocolitis

Congenital cardiac surgery

Neurosurgery

Organisation of Care - Clinical Challenges

- DGH Workload and need for accurate documentation of workload
- Widespread Nature of Care
 - 98 hospitals less than 500 operations were performed a year and some of these hospitals performed very few procedures

Organisation of Care - Clinical Challenges

- Transfer of Care and Inter Hospital Transfer
 - Policy in place for the majority of hospitals but 10 did not!
 - Major improvements in Neonatal and PICU transfer since 1999
 - Transfer method for less urgent care should be agreed in advance (Role of receiving centre)
 - Lack of documentation in 78 cases

Organisation of Care - Clinical Challenges

Management of the sick child;

- Yes – “All hospitals that admit children as an inpatient must have a policy for the identification and management of the seriously ill child.”
- “This should include track and trigger and a process of escalating care to Senior Clinicians”

Clinical Challenges – Track and Trigger

Cardiff and Vale Paediatric Early Warning System (C&VPEWS) abnormal criteria (Based on APLS criteria)

1. Airway threat e.g. stridor
2. Child requiring any amount of O₂ to keep Saturations >90%
3. Respiratory rate (outside the range below)

Respiratory rate	<1	20-50
1-2	15-45	
2-5	15-40	
5-12	15-35	
>12	10-30	
4. Abnormal respiratory observations i.e. recession or accessory muscles used
5. Bradycardia or Tachycardia (outside the range below)

Heart rate	<1	90 – 160
1-2	80 – 150	
2-5	75 – 140	
5-12	60 -120	
>12	55 -100	
6. Blood Pressure (outside the range below)

Systolic Blood Pressure	<1	70-90
1-2	80-95	
2-5	80-100	
5-12	90-110	
>12	100-120	
7. Level of Consciousness (abnormal if only responding to voice or less)
 - A ALERT
 - V Responds to VOICE
 - P Responds to PAIN
 - U UNRESPONSIVE
8. Nurse or Doctor *worried* about clinical state

ED Edwards, CVE Powell, BW Mason, A Oliver. Prospective cohort study to test the predictability of the Cardiff and Vale Paediatric Early Warning Score (C&VPEWS). *Arch Dis Child* 2009;**94**:602-606.

Clinical Challenges – Track and Trigger

- Scoring systems based on physiological parameters are appealing
- To date validation studies have not shown trigger criteria that have high sensitivity that is not at cost of low specificity
- If available trigger criteria were implemented completely RRT's would be called frequently to children who would not go on to develop critical illness
- High grade evidence on effectiveness of RRTs i.e. RCT's is not available
- Practical difficulties implementing RRT's in DGH's
- Identifying children likely to develop critical illness can be difficult
- C&VPEWS based on APLS guidelines “Recognition of the sick child” would frequently trigger the PETS team unnecessarily
- It does not discriminate between unwell children and those who develop critical illness

Clinical Challenges – Track and Trigger

Don't use a PEWS as a substitute for....

Empowering the team to ask for help

Looked at your communication systems

Made sure the observations charts are completed accurately

Educated the team in recognising sick children properly

Be aware that you team might be called to many false positives and any tool out there will still miss children who go on to develop critical illness.

Organisation of Care - Clinical Challenges – Track and Trigger

- “NICE Needs to Develop guidance for the recognition of and response to the seriously ill child in hospital”

Need for review of complex area > 20 PEW's

Cut off's to be used?

Score or trigger?

Which tool?

- Yes –“The presence of onsite resuscitation teams is a prerequisite for all hospitals”

Organisation of Care - Clinical Challenges

- Audit and Governance
 - All hospitals that undertake surgery in children must hold regular multidisciplinary audit and morbidity and mortality meetings that include children and should collect information on clinical outcomes related to the surgical care of children
 - 53% stated they had meetings (4 with high volumes)
 - **Answer - REVALIDATION**

Individual Care

Congenital cardiac surgery

The level of care for children was generally good

Necrotising Enterocolitis

Decision making – MDT

Further research needed medical and surgical management is difficult

Neurosurgery

Organisational Review – Safe and Sustainable Review of Children's Neurosurgical Services

Transfer delay – Need Pathways of Care

Other Reflections (1)

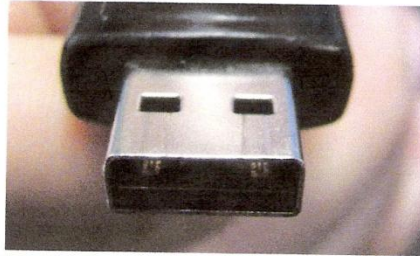
“Case note retrieval proved much more difficult. Several Trusts were unable to locate the clinical records”

Tougher penalties planned for NHS data losses

Information commissioner Christopher Graham says fines of up to £500,000 could be imposed for Data Protection Act breaches

Press Association
• guardian.co.uk, Friday 1 July 2011 11.26 BST

A larger smaller



NHS staff have lost memory sticks, laptops and documents, which have caused data protection breaches. Photograph: Matthew Baker/PA

The information commissioner has called for tougher penalties on NHS trusts and hospitals who lose patients' personal medical records.

Christopher Graham said fines of up to £500,000 could be imposed to counter what he called a "disturbing" culture in the health service. Millions of records are believed to have been lost by health organisations in data breaches, which include staff losing laptops, memory sticks and documents.

In an interview in the Independent Graham said: "There's just too much of this stuff going on. The senior management is aware of the challenge but the breaches continue. Whether it's a systemic problem in the NHS or an epidemic we have got to do something about it. Health service workers look after their patients very carefully but don't always look after their data very carefully."

Graham has requested a meeting with the chief executive of the NHS, David Nicholson, to discuss the problem. "It's a much wider problem and we do need some tougher penalties because the courts don't seem to regard it as a terribly serious offence," he added.

He made the comments as he revealed that five more health organisations had agreed to improve security following major data breaches – all can be prosecuted under section 55 of the Data Protection Act.

They included Ipswich Hospital NHS Trust, which saw a staff member misplace 29 records; East Midlands Ambulance Service NHS Trust; Lancashire Teaching Hospitals NHS Foundation Trust; and Basildon and Thurrock NHS Foundation Trust.

The commissioner was also investigating how the NHS North Central London Trust lost a laptop containing an estimated 8.3 million patient records.

Graham added: "It could either be deeply embarrassing and upsetting to people who are not well. But also it's a source of personal information which can be abused for all sorts of purposes about identity theft, blackmail or whatever. There's a market in the unlawful disclosure of personal information that's supposed to be protected by the Data Protection Act."

Other Reflections (2)

- Autopsy and Pathology
 - “If only the overall care demonstrated in paediatric autopsy pathology was matched by similar performance in the adult arena, the prognosis for quality UK autopsy pathology would be much more positive than is the case at present”
 - Children are special

In Summary –The Way Forward

- This report is important and necessary as it highlights deficiencies in the care of children.
- Strong evidence for constructive recommendations from NCEPOD to improve care.
- Many of the solutions rest with good local clinical leadership and a greater focus on safety and quality.
- There are National initiatives/drivers that can facilitate change.

Summary – The Way Forward (Contd)

- Further review needed

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.

Donald Rumsfeld

Thank You