



CrossMark

Highlights from this issue

R Mark Beattie, *Editor in Chief*

IS IT TAKING LONGER TO DIE IN PAEDIATRIC INTENSIVE CARE

Childhood mortality is falling with the majority of child deaths being in children with chronic health problems. Data from the UK Paediatric Intensive Care Audit Network (PICANet) show that crude mortality in British paediatric intensive care units (PICUs) has followed the national trend and fallen consistently from 5.5% in 2003/2004 to 3.7% in 2013. While survival is improving, the prevalence of life-limiting illness and chronic disease in British children is increasing. This is during a period of considerable growth in the provision (and availability) of paediatric intensive care. Plunkett *et al* explore some of the factors that may influence length of stay (165, 473 admissions, 10 years). Length of stay increased by 0.31 days/year (CI 0.169 to 0.449) in non survivors and by 0.064 (95% confidence interval 0.046 to 0.083) in survivors. Proportion of early deaths (within 24 hours of admission) fell by 0.44% points per year but the proportion of late deaths (>28 days) increased by 0.44%. This overall increase in length of stay is driven by a reduction in early deaths and increased proportion of late deaths. The authors conclude that this data suggests that the scenario of an early death in paediatric intensive care unit (PICU) following treatment failure may be being replaced by the death of a child at the end of a long PICU admission. This has implications for children with life limiting conditions. There is an excellent accompanying editorial—Dying later, surviving longer—which discusses the dataset and its implications. *See pages 788 and 783*

PATHWAYS BETWEEN HEALTH, EDUCATION AND INCOME IN ADOLESCENCE AND ADULTHOOD

It is well known that children from poorer families have a higher risk of developing chronic health conditions and that ill health has a significant negative effect on labour force participation in adults. Callender explores the impact of household income, and physical and mental health in adolescence on education attainment, household income and health status in adulthood (n=655; 48% male). The data is quite striking. In essence physical health at age 17/8 was significantly related to level of educational achievement at age 29/30 with the influence of this being greater in magnitude than that of household income at age 17/18 on level of education achievement at age 29/30. Females physical

health at age 17/18 was also significantly related to household income at age 29/30. The findings were similar in males. The data is in the paper. The odds ratio of achieving a year 12 or higher level of education attainment was 4.72 (95% CI 1.43 to 15.58) for females and 5.05 (95% CI 1.78 to 14.36) for males compared with those with poor physical health at age 17/18. The authors conclude that as physical health in adolescence appears to have a stronger influence on education attainment in adulthood than household income, equity strategies for education attainment should also target those with poor health. *See page 825*

LEARNING FROM EXCELLENCE

Tell me how you measure me, and I will tell you how I will behave.

Eliyahu Moshe Goldratt

Patient safety is a key component of the strategy to improve the quality of healthcare delivery. This is (mostly) focused on identifying adverse incidents and errors and implementing change to avoid their recurrence. This is essentially reactive. The process is widely encouraged across the NHS. There is the potential however for a negative impact on health care workers depending on the processes within organisations, feedback and strategies to deal with and manage staff involved. In a leading article *Kelly et al* discuss the more positive approach of learning from excellence in healthcare as a new approach to incident reporting. This clearly can't replace adverse event reporting as these issues need to be flagged up and dealt with in order that changes can be made to try and reduce the potential for recurrence. If however positive incidents and experiences are reported—essentially what has gone well, why did it go well and how can we best learn from it—there is the potential to create a more positive culture of reporting and learning. This 'nurturing' of positivity within individuals and teams is likely to lead to improved resilience and ability to deal with adversity. The authors discuss some of the practicalities of the process introduced into their unit—the learning from excellence initiative. Incidents are submitted electronically and discussed at an IRIS (Improving Resilience, Inspiring Success) meeting with in depth investigation of some using an Appreciative Inquiry (AI) approach. The feedback has been very positive and led to Quality Improvement Initiatives which focus

on 'gold standard' management rather than deficit reduction. This is an important paper and Editor's choice this month and reflects a progressive approach moving from a culture whereby we tend to discuss adverse events and how to avoid them to discussing all aspects of care and how to make that care better. *See page 788*

PUBLISHING QUALITY IMPROVEMENT

We are keen to publish quality improvement which impacts on clinical practice and can demonstrate that a clearly defined intervention has resulted in change which is positive, sustainable and transferable for implementation in other centres. This can be as a full original article (see instructions for authors) or as a short report. For a short report the intervention needs to be clear with a brief abstract then Introduction, Methods, Results and Discussion. Don't forget to highlight what is known, what this study adds. I would like to highlight two articles published in the journal this month. The first discusses structured, supported feeding admissions for restrictive eating disorders on paediatric wards and how to make it work and thereby reduce the need for specialist inpatient eating disorder unit admissions. It is a great example of effective joint working between paediatric medical and mental health services. The second relates to introduction of a care bundle to improve eye care to children in the paediatric intensive care unit. Both are excellent reads—informative, practical and helpful. *See pages 832 and 836*

IMPACT FACTOR

I am delighted to tell you that our 2015 impact factors for *ADC* and *FNN* went up significantly with the *ADC* impact factor increasing from 2.899 to 3.231 and the *FNN* impact factor increasing from 3.12 to 3.969 (ranked 4th in paediatric journals). The impact factor reflects how well the articles published in our journal are cited by authors which means the 2015 impact factor is the number of citations during 2015 to articles published in 2013–2014 divided by the number of articles (original articles, reviews, leading articles) published in 2013–2014. Both impact factors are the highest ever for the two editions and reflect the excellent content submitted, the hard work of the editorial team and authors as they process content and the excellent BMJ publishing team who produce the journal. Keep sending us your papers.