next step will be to publish these more widely to all stakeholders to drive further improvement in our training units.

Thank you to everyone that helped.

REFERENCES

1. Trainee Charter, Royal College of Paediatrics and Child Health
2. Trainee Toolkit, Royal College of Paediatrics and Child Health

Aims

There is a general perception about time to contact medical services and automated messages to navigate, with hardly any mention of children. Previous work showed that medical services and automated messages to navigate, with

Methods

Using the A-Z ‘Acute (Hospital) trusts’ directory on the NHS Choices website, the main contact number for each NHS Trust was obtained. Numbers were dialled once after 5pm from the same mobile and network provider. We recorded how many times it rang before answered, whether there was an automated message or not.

Where there was an automated response, characteristics were assessed, including: length, male/female/computerised voice, use of voice recognition, menu choice, references to Covid, instructions provided for urgent situations, and mentions of children.

Results

Of 225 NHS Trusts listed, 46(20.4%) of numbers were effectively unobtainable, with 22 providing a short message to call back within office hours. The remaining 179 NHS Trusts, 57.5% had a number specifically dedicated to that NHS Trust, the rest directed callers to one of their hospitals. When numbers functioned they were answered in mean 1.7 (2.2-3.1) rings. Automated messages were in 146 NHS Trusts. Automated messages answered in 0.6(0.57-0.68) rings, around 2 seconds. Without automation it took 6(5-7) rings, which was statistically significantly longer, around 20 seconds.

The mean length of automated messages was 44(26-48) seconds:

• 57.5% were human voices, and 37.7% computer generated
• 78.1% were female voiced
• 96.4% of computer generated messages seemed female
• 59.6% of messages did not offer any interactive elements
• 12.3% offered voice recognition
• 28.1% offered menu choices
• 59.6% did not triage calls, but were used to welcome the caller, mention covid visiting, or both
• 83.6% placed callers in the operator queue after the message

• 51.4% referred to Covid, instructing the caller regarding symptoms or visiting
• 8.2% offered instructions for urgent situations other than covid
• Only 4.1% of trusts mentioned children, 83% of which were about visitor rules for child inpatients

Conclusion

The NHS Choices directory needs updating. NHS Trusts with automated messages will answer faster, but automated switchboards require a longer wait before people will interact with a human, as the telephone is answered in around 2 seconds (0.6 rings) there are still about 44 seconds to wait until the caller gets to a human.

Hospital messages are shorter than primary care ones. Children are not part of most NHS trust responses. Qualitatively most messages were not helpful.

There is a shocking lack of voice recognition despite the wide use of voice recognition software in many spheres of life.

REFERENCE


Handover- A Potentially Perilous Procedure?

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Aims

The aim of this study was to assess the number and quality of paediatric ward handovers taking place in a busy district general hospital. The goal was to assess the efficacy of handover and identify any factors potentially impacting adversely on the hand-over experience.

Methods

Data was collected over a 30-day period from 05/10/20 – 03/11/20. The data was collected using ‘audit sheets’ completed by the ward tea. The audit sheets included sections on:

• Time of handover (morning, post-ward round, afternoon and evening/night handover)
• Safety brief
• Duration of the handover
• Location handover took place
• Number of interruptions

Results

A total of 66 handovers were audited over the 30-day period, i.e. approximately 59% of the total number of handovers that would have been expected during this time.

• 80% of the handovers in the audit were morning handovers where the night team hand over to the daytime team.
• Afternoon handovers were the most poorly documented (only 10 documented total).

All handovers took place on the ward or in clinical settings, in large part due to COVID 19 restrictions centred around social distancing and space availability.

All documented handovers were timely, taking 30 minutes or less with appropriate numbers of people present including the consultant and senior nursing staff.

17 interruptions were documented, of which one was urgent, 56% of non-urgent interruptions occurred during the evening handover with the night team. All interruptions by the ED department occurring during the evening sessions.

Conclusion

The data collected showed that most handovers are effective and performed well, however nothing is perfect!
Interruptions – designating a fixed time and place for handover
A significant number of interruptions were noted. This revealed the need to revisit protocols with other medical teams to ensure protected handover time.

A variety of locations for handover were recorded. A static/designed location would contribute to reducing interruptions.

Huddles and Handovers As a result of the concerns highlighted around the afternoon handover, it was agreed to pilot an early afternoon ‘huddle’, between the junior team and the consultant, to discuss patient status and referrals. This less formal interaction, in the early afternoon, would allow time for troubleshooting ‘in-hours’ to address issues and improve patient safety.

Pre-handover Huddle – a new model?
The concept of huddles in health care is well documented and advocated by many practitioners. I feel there is merit in exploring the use of huddles as a ‘default practice’ in front of all handovers to ‘hone’ the critical information that is to be shared at handover and to confirm priorities.

In essence this reimagining of the huddle is where teams come together to review earlier planned actions ahead of formal handover.

This use of a huddle would ensure that the handover is ‘factual’, not ‘opinion seeking’, and could minimise out-of-hours avoidable decision making, e.g. referral for scans or other specialist teams input. The use of a huddle pre-handover would allow the ‘in-hours’ team to initiate actions that could allow the next team to ‘hit the ground running’.

Aims Moving from paediatric to adult services is a worrying and challenging time for young people with long-term conditions. Evidence suggests that effective transition between services can improve long-term outcomes, yet national data highlights that transition is often overlooked with little recognition as an area of importance within healthcare. However, there has recently been a drive to refine and improve the transition process through the NHS long term plan. This quality improvement project aimed to achieve the NICE Quality Standards for transition for 6 sub-specialties in one paediatric department, across a nine-month period.

Methods An initial gap analysis was undertaken using 11 NICE quality transition-focused standards of care to demonstrate current performance of services for transition for 6 sub-specialties: allergy, asthma, diabetes, epilepsy, HIV, and sickle. Diagnostic tools including a process map, fishbone diagram, histogram and RAG rating were completed to help define the problem further. Following this, change ideas were generated and several PDSA cycles were conducted through transition workshops, regular progress meetings and implementation of individualised action points for each sub-specialty.

Results Baseline measurement following the initial gap analysis showed that only 18% of standards were partially met and 45% of standards were met across the 6 sub-specialties. Diabetes, HIV and Sickle showed better performance, meeting at least 6 out of 11 standards of care for transition. Following the implementation of individualised action points and transition workshop meetings, the baseline measurement for partially meeting and meeting standards increased to 30%, and 58%, respectively. Standards 1 and 2 still require improvement across all specialties. Importantly, specialties such as asthma and epilepsy showed significant changes in partially meeting or meeting standards.

Conclusion This quality improvement project has enabled one paediatric department to better achieve the NICE standards of care for transition for young people with long-term conditions. Highlights during the process included: external talks from a transition improvement manager and a transition nurse consultant, regular transition workshop meetings and successfully obtaining funding for a new epilepsy transition specialist nurse through Roald Dahl’s children’s charity. In addition, there was implementation of the Ready, Steady, Go, paperwork, joint clinics between paediatric and adult services for asthma and epilepsy, along with asthma transition clinics within the local community.

Measurable progress has been made in implementing transition-related standards of care, however; further work is needed to ensure young people and their families are actively involved in the design, delivery, and evaluation of transition services. Importantly, ongoing work is required to ensure that transition-related standards of care are met and provided for young people when moving from paediatric to adult health care services.

(1) Implementing Transition: Ready Steady Go, Arvind Nagra
(2) From the pond into the sea, children’s transition to adult health services, CQC
(3) Transition from children’s to adults’ services, NICE Quality Standards

Aims Effective transition is a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare in paediatric and adult services. NICE guideline recommends that the transition should be a joint clinical action between paediatric and adult service, with at least 1 joint consultation and a clear action plan for conducting a review after the young person has transferred into the adult service.

Aims and Objectives To evaluate and provide recommendations to the Paediatric Epilepsy service regarding the smooth and efficient transition process to Adult Epilepsy service.

We assessed if an epileptic child with normal development completed the transition process by 17th birthday, whereas an epileptic child with neuro-disability and learning difficulty completed the transition process by 19th birthday.

We also determined the reason for the delay in transition and the number of patients in whom transition did not happen in ideal condition (seen by a specialist nurse and joint transition clinic)