London acute care standards for children and young people

Driving consistency in outcomes across the capital

Revised August 2016

About this document

These standards bring together a number of children's standards into one document. In the first instance, it was developed by the London Children and Young People's Strategic Clinical Network.

It has been revised by the Healthy London Partnership's Children and Young People's Programme (August 2016). We would like to acknowledge the work of the numerous organisations referenced throughout.

Contents

Introduction

Purpose

The Healthy London Partnership (HLP) is a collaboration between London's 32 clinical commissioning groups and NHS England London region to support the delivery of better health in London.

The Healthy London Partnership's transformation programme for children and young people aims to rebuild healthcare around London's children and young people with five key areas of focus:

- develop population-based networks to promote health and co-ordinate care
- reduce variation in quality of services
- integrate care across public health and primary and secondary healthcare services
- develop commissioning of children and young people services to enable the effective commissioning of pathways of care
- develop innovative access models of care.

Acute care standards for children and young people

In seeking to reduce the variation in quality of services, the Children and Young People's Programme acknowledges the work done by the London Children and Young People's Strategic Clinical Network to identify and bring together standards already in existence relating to the acute care of children and young people (CYP).

Standards were located in publications from a large number of organisations and more than 800 standards related to acute care alone. Extensive work was undertaken to collate these into one document which set out the minimum standards which should be delivered in acute, secondary and tertiary services for children and young people in London.

As there was extensive similarity and overlap across many of the standards, the standards have been worded to capture the essential meaning of the multiple sources. However, the original sources have been included and cross referenced. Commissioners and providers are encouraged to read the original sources as well as this document.

The original document was published in April 2015. However, it was always recognised that over time new standards of acute care would be agreed and that any such standards would need to be incorporated into the ***London Acute Care Standards for Children and Young People***, as appropriate. In the succeeding 12 months, a number of key documents have been published that relate to acute care services for children and young people.

For the most part, the changes that have been incorporated reflect:

- Royal College of Surgeons: Standards for non-specialist emergency surgical care of children; (November 2015).
- Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications; (November 2015).
- NICE guidelines [NG43]: Transition from children's to adults' services for young people using health or social care services (February 2016).

Where changes have been made to the original document, these are listed in the appendix.

Audience

This document is aimed at commissioners and providers of acute care services for children and young people. It has brought together information and standards of care into one place to enable the effective commissioning of services which meet these required minimum standards. Providers can use these to undertake a self assessment of their ability to deliver the required quality of acute care for children and young people. They can be used to validate, challenge and to quality assure services.

Utilisation and implementation of these standards will help to reduce the variation in the care delivered to children and young people across the capital. They will also help to reduce the enormous variation in outcomes experienced.

Inclusions

The standards outlined in this document relate to acute care services provided in hospitals where there is an in-patient facility for children and young people.

For the sake of clarity, the standards do not apply to urgent care centres; either in-house or standalone.

Where acute care services are provided in hospitals where there is an in-patient facility for children and young people, the standards apply to seven day services. There is no difference in the provision of services during the week compared to those at the weekend.

All services must meet the Care Quality Commission's fundamental standards of care and Section 11 of the Children Act (2004) as well as the 2013 document on interagency Working Together to Safeguard Children.

Exclusions

All specialised services, including neonatal, that are additionally commissioned against the appropriate national specialised service specification. However, these standards are an adjunct to the requirement of the service specifications, and should be used in conjunction with them. Standards relating to general hospital requirements are not included (e.g. staff appraisal policies, medical devices standards, moving and handling competencies, service-specific competency frameworks and professional body guidance on professional standards).

Notes

In this document the term children or child should be taken as meaning children and young people under the age of eighteen years. They also take into account young people aged 16 – 25 who are undertaking transition to adult services, including those with more complex needs.

The term multidisciplinary team is used throughout this document. The composition of an acute care multidisciplinary team will vary according to need. There also needs to be close collaboration with community teams, local authorities, social care, local education, school nursing, GPs, continuing healthcare nursing, child and adolescent mental health services (CAMHS), psychology, occupational therapy (OT), physiotherapy (PT), speech and language therapy (SLT), community paediatric and district nursing teams.

Further standard development

The Healthy London Partnership is aware that these standards do not describe all areas of care for children and young people.

Readers are asked to note that two further sets standards will be published shortly:

- Healthy London Partnership, Children and Young People Programme: Children's Surgical Networks: Emergency Surgery, Framework and Standards.
- Healthy London Partnership, updated Paediatric Assessment Units Standards.

The Children and Young People's Programme will continue to develop additional standards across a variety of care settings. Community standards and out of hospital care will be the next areas of work for the programme.

Commissioners and providers would be expected to incorporate these into planning once published.

Both in developing and implementing standards relating to service provision for CYP, care must consider the needs of the child including culture, beliefs and ethnicity and should be based on the United Nation Convention on the rights of a child that says that every child has the right to:

- A childhood, including protection from harm.
- Education, including completion of primary school for all girls and boys.
- Health and health services, including clean water, nutritious food and medical care.
- Fair treatment, including changing laws and practices that are unfair on children.
- Be heard, including consideration of children's views.

London's ambitions for children and young people's networks

Some of the issues in delivering effective healthcare to children and young people arise because of the fragmentation of services and commissioning structures and the lack of integration of providers. This applies to services in primary, secondary, tertiary and community care.

Analysis of serious incidents has shown that children and young people are often subject to a failure of care when moving across care settings. More effective linkages between providers and commissioners would help to reduce these issues.

Therefore, a model of population-based networks based on such linkages across all settings is proposed to address these issues. This is strongly aligned with *NHS England's Five Year Forward View*, which acknowledges that traditional divides between different parts of the health system act as a barrier to co-ordination and personalisation of care. It recommends dissolving these boundaries to ensure more effective co-ordination of care. New models will emerge over time and the Healthy London Partnership is keen that care for children and young people is central to these developments.

A. INSTITUTIONAL COMMITMENT		EVIDENCE	REF
The following statements identify the requirement for CYP services to have commitment from the board and the appropriate governance structures in place to ensure a safe, consistent level of quality is provided to all children and young people, parents and carers.			
Infrastructure			
Involvement of trust board			
1	It is recommended that each trust with services for CYP has a named executive board member with board level responsibility, covering all aspects of care for CYP aged 0-18 years and for the care of young people up to the age of 25 with more complex needs. This should include responsibility for quality, safety and safeguarding of these children and young people. In addition it is recommended that there is a non-executive director or designated representative who also holds responsibility for quality, safety and safeguarding of children and young people. The executive board members chair an appropriately constituted governance committee for CYP, reporting directly into the board with the following clinicians responsible for children's services as minimum membership: ■ Lead clinician for CYP services ■ Consultant paediatrician ■ Senior children's nurse and other relevant health professionals ■ Consultant anaesthetist ■ Consultant in emergency medicine ■ Consultant surgeons (general and specialty) ■ Consultant radiologist or senior radiographer ■ Senior children's manager ■ CYP and parent representative ■ Designated / named nurse and doctor for safeguarding ■ CAMHS representative The governance committee is responsible for regional audit, standards and care pathways. The committee undertakes self assessment of the trust (and each individual hospital site, if applicable) against the HLP acute care quality standards The safeguarding governance committee reports into the governance committee for CYP.	■ Demonstrated in published plans, reports and in management structure to support the service ■ Governance structure ■ Terms of reference, membership and accountability of the group (Note: This group may have other functions as long as the standard is met in relation to terms of reference, membership and accountability.) ■ Evidence in minutes of regular discussion at board level ■ Role identified in the job plan with evidence of review at appraisal ■ Evidence of audit and compliance against standards ■ Self assessment against HLP acute care standards for CYP and action plan ■ Evidence of safeguarding structures ■ Evidence that operational policies regarding provision of CYP services are reviewed regularly by governance committee	1, 4, 5, 6a, 6b, 7, 8, 9, 23, 57, 58
2	The trust has operational policies in place agreed by the trust board for the following: ■ Paediatric service ■ Management of the acutely unwell child, including transfers and management of life saving interventions ■ Surgery and anaesthesia in children and young people, including management of life saving intervention in these circumstances ■ Imaging and pathology services ■ Mental health services within paediatric acute care ■ Emergency Department ■ Pain assessment and management of pain in children ■ Transition to adult services ■ Safeguarding	■ Current operational policies ■ Role identified in job plan and reviewed at appraisal ■ Discussion of data in minutes of governance committee and escalation to trust board when required	6a, 6b, 8, 23, 57, 58

A. INSTITUTIONAL COMMITMENT		EVIDENCE	REF
Infrastructure			
Governance and audit			
3	There is a programme of audit across all elements of the service. All services that manage children are aware of, submitting data to and participating in appropriate national, regional and local clinical audit programmes.	■ Submission of data to national audit programmes » TARN » CEM audits relating to children » National Paediatric Diabetes Audit » Oncology (if applicable) » Epilepsy 12 » CQC » Other relevant national audits » PROMs and PREMs ■ Data is benchmarked against national outcomes where available ■ Evidence of SHMI data reviewed regularly ■ Mortality and morbidity and outcomes reviews ■ Participation in CDOP panels ■ Quality and safety dashboards and action plans ■ Effective investigation and action plans following SIs	1, 4, 5, 6a, 6b, 10, 11, 22, 23, 57
4	Each trust has a comprehensive directory of services, contacts details and referral guidelines, completed separately for each hospital site.	■ Current updated directory of services	
5	The service meets the current staffing data recommendations and the board receives data on staffing capacity and capability quarterly.	■ Staffing records and rotas ■ Discussion of staffing in board papers	7, 51
6	The unit produces a CYP annual report summarising activity, compliance with quality standards, and clinical outcomes. This report is shared with all referring hospitals, primary care clinicians, community care and all commissioners.	■ Annual report	5, 23
Involvement in local networks			
7	Trusts delivering care to CYP demonstrate commitment to participation in a population based CYP network which links with providers, commissioners, public health, local authorities and involves CYP and their families. Shared pathways and protocols and workforce planning are developed across the network. There is evidence of collaboration between all sectors including local children's safeguarding boards.	■ Network terms of reference and hosting arrangements ■ Trust participation in network meetings ■ Shared network protocols and guidelines ■ Regular assessment of performance in place ■ Workforce planning ■ Examples of measures to improve service delivery across the network ■ Evidence of collaborative working with LSCBs	4, 5, 6a, 6b, 7, 9

A. INSTITUTIONAL COMMITMENT		EVIDENCE	REF
Involvement in local networks			
8	There is a directory of all surgical specialties and age ranges available within the surgical network as indicated with surgical network standards. Networks have clear protocols describing how services at other sites will be provided elsewhere through network arrangements (e.g. diagnostics, surgery, interventional radiology, endoscopy, all tertiary services).	■ Directory of services ■ Operational policy ■ Evidence of regular audit of London-wide standards for CYP surgical networks on children including number and timeliness of transfers and outcomes	6a, 6b, 11, 12
B. GOVERNANCE AND ACCOUNTABILITY			
Quality and safety			
There is evidence of continuous assessment and ongoing service improvement which includes patient and family feedback and involvement in service development.			
Audit and data (minimum dataset, dashboard)			
9	The Urgent and Emergency Care Clinical Audit toolkit is used to review individual clinician consultations systematically wherever children with urgent care needs are assessed, including on the telephone, face to face, in hospital or in the community.	■ Evidence of audit of consultations using toolkit	6a, 6b, 51
10	There is use of national minimum dataset that incorporates the specific needs of children and participation in regular required audits, such as safeguarding.	Evidence of use of national datasets such as: ■ Maternity and Children's Data Set which incorporates : Children and Young People's Health Services Data Set ■ Mental Health Services Data Set (MHSDS) ■ Evidence of safeguarding audit programme	Proposed by CHIMAT
11	There is a trust/network-wide audit of emergency surgery in children. Emergency children's surgical practice is audited at minimum annually using routinely collected data. The audit includes children's surgical transfers and untoward incidents, including unplanned readmissions.	■ Regular audit, outcomes discussed at board level with evidence of feedback to improve services	6a, 6b, 11
Mortality and morbidity			
12	Multidisciplinary audit and morbidity and mortality meetings are held regularly. When a death occurs within 30 days of surgery a multidisciplinary meeting is convened and a note made in the clinical record. There are regular morbidity/mortality multidisciplinary team (MDT) reviews of individual cases to identify areas of good practice.	■ Evidence of morbidity and mortality meetings ■ Evidence of SI reports, action plans and learning ■ Notes and actions from morbidity and mortality MDT meetings	5, 6a, 6b, 11
13	All providers must participate in child death overview panel (CDOP) process as required. Audits of all child deaths, including those with any safeguarding components.	■ Evidence of participation in CDOP panels from minutes of meetings and attendance lists	6a, 6b, 13

B. GOVERNANCE AND ACCOUNTABILITY		EVIDENCE	REF
Tracking and responding to SIs and complaints			
14	There are processes for: ■ Identifying and discussing serious case reviews (SCR) ■ Critical incidents and complaints ■ Monitoring action plans ■ Auditing care pathways ■ Developing plans for quality improvement. Audit activity includes the regular analysis of untoward incidents. Never events, serious events and near misses are thoroughly investigated and reported to the trust board and relevant national agency, in line with national requirements.	■ Evidence trust engages with quality review processes with commissioning organisations ■ Evidence of submissions onto STEIS ■ Evidence of effective SI/ SCR investigation and action plans ■ Minutes from meetings	5, 6a, 6b, 14, 15, 22, 23
Protocols and guidance			
There is evidence of continuous assessment and ongoing service improvement which includes patient and family feedback and involvement in service development.			
15	Trust are guided by protocols and guidance based on NICE guidance and evidence based practice, including infection, prevention and control practices and the use of national toolkits.	■ Use of protocols, guidance and appropriate toolkits	4, 5, 6a, 6b, 12, 16, 17, 18, 23, NICE
Information technology (IT)			
16	The trust has, or is moving towards, a strategy that ensures communication between diverse IT systems in hospital, the community and all child healthcare settings. It uses a unified clinical record throughout the patient's journey, commenced at the point of entry, and is accessible by all healthcare professionals and specialties throughout the care pathway (community to tertiary). This includes the ability to flag/code any concerns (e.g. any child subject to plan).	■ Strategy available ■ Evidence of unified record	4, 6a, 6b, 19, 20
C. PATIENT AND FAMILY EXPERIENCE			
This not only includes the experience of the patient and carer going through the service, but also demonstrates how they are Involved in the assessment, running and development of any future services.			
17	CYP and families are actively involved in giving feedback on services to improve patient experience.	■ Evidence of patient involvement in decisions about service development in minutes ■ Patient experience measures are in place/ feedback regularly audited and fed back ■ Evidence that complaints are used to improve services	6a, 6b, 20, 27
18	Young people are routinely involved in reviewing local service provision against the Department of Health's Quality criteria for young people friendly health services.	■ Evidence CYP have core involvement in relevant consultations and review processes	20
19	All trusts participate in routine NHS surveys for CYP (e.g. CQC's national inpatient survey, Friends and Family Test, PROMS and PREMS), and action plans findings are reviewed by board and disseminated.	■ Evidence of reporting and action plans	4, 20, 21

C. PATIENT AND FAMILY EXPERIENCE		EVIDENCE	REF
Family support / information provision			
20	Children, young people and their families receive sufficient information, education and support to encourage and enable them to participate actively in all aspects of their care and decision making. This means information is tailored to their needs and is in an accessible format throughout the care pathway (written information, pictures, symbols, large print, Braille and different languages). Staff must be available to explain what is happening and the plans for care	■ Portfolio of information available	4, 22, 23, 57, 58
Confidentiality and consent			
21	All clinicians involved in care for 0-18 year olds are familiar with current legislation around consent, competency, confidentiality, mental capacity and safeguarding data protection, human rights and Children Act 2004. The adult Mental Capacity Act is considered for older children.	■ Evidence of training available for staff ■ Audit of number of staff trained for knowledge through survey of staff	1, 2, 6a, 6b, 19, 20, 23, 51
22	There is a standard operating procedure or process on confidentiality and consent, consistent with current DH guidance. All staff are aware and processes exist which ensure regular review of consent and confidentiality policies.	■ Written policy on consent to treatment processes in place ■ Audit of staff training and knowledge	1, 20
23	Confidentiality and consent policies are made explicit to young people and parents and carers, supported by appropriate publicity materials. The information makes clear young people's entitlement to confidentiality and notes any limitations to confidentiality with regard to safeguarding. The service routinely explains to young people that they have the opportunity to attend a consultation without the involvement of a parent or a carer. Information is available in formats and languages appropriate to the needs of the patients and their families.	■ Standard operating procedures on consent to treatment processes in place ■ Examples of information for children and parents. ■ Results from feedback surveys of parents and carers ■ Accessibility of relevant materials	4, 9, 19, 20, 23
D. INTEGRATION AND CARE CO-ORDINATION			
Services for children, young people and their families are provided by a range of health, community and social care professionals and agencies working collaboratively to ensure the highest standard of care for children and young people at all times.			
24	Arrangements for the handover of children at each stage of changeover of responsible consultant is built into job plans.	■ Evidence of handover process and documentation	4, 6a, 6b, 9, 12
25	There is a system to communicate the name of the responsible consultant to patients and families on admission and at every change of consultant responsibility.	■ Audit of CYP and family awareness of responsible consultant	4, 6a, 6b, 12
26	Support services, both in the hospital and in primary, community and mental health settings, must be available seven days a week to ensure that the next steps in the patient's care pathway are taken, as determined by a daily consultant-led review.	■ Description of services and care pathways, audit of notes, rotas	12, 23, 24
27	Healthcare systems and processes, policies and procedures are in place to support healthcare professionals' practice during palliative care and when a child dies (e.g. CDOP). Local checklists based on national recommendations are used in all care settings.	■ Evidence of policy, process and checklist in place	6a, 6b, 13, 51
28	Parents and children are offered an appointment to see the bereavement counsellor swiftly and a relevant consultant at a suitable time interval.	■ Audit of notes	5, 6a, 6b, 23, 51

D. INTEGRATION AND CARE CO-ORDINATION		EVIDENCE	REF
Discharge / care planning			
Commenced on admission in order to provide a smooth transfer back to primary care (or other care, as appropriate).			
29	Systems are in place to ensure safe discharge and transfer between providers including: ■ All admitted CYP have discharge planning and an estimated discharge date as part of their management plan as soon as possible, and no later than 24 hours post admission. ■ The primary care team/GP is informed of discharge within agreed timescale of each attendance (including community nursing teams, health visitor and school nurse). ■ Information is provided to GP and community teams electronically within 24 hours of discharge. ■ Clear written information and advice are provided to families which includes what to do, when and where to access further care if necessary, along with clear instructions on follow up and arrangements in case of post operative emergency at home. This includes telephone advice. ■ Post discharge there is liaison between the acute and community services, and community children's nurses are available to provide support to patients and family	■ Standard written discharge information ■ Audit of discharge planning and timelines ■ Evidence of telephone advice offered/ feedback from patients/supporters/ description of telephone follow up service and GP links	4, 6a, 6b, 12, 23, 51
Transition to adult services			
Transition to adult services should be as seamless as possible for the young person. For groups not covered by health, social care and education legislation, planning for adulthood should start from year 9 (age 13 or 14) at the latest and last until 25. The process of transition is expected to take longer where a child has complex needs. Transition should remain flexible at all times. For young people entering the service close to the point of transfer, planning should start immediately.			
30	There is a clear lead clinician responsible for transition leading work on policies and pathways of care to prepare young people for the transition to adult services across the trust.	■ Operational policy for paediatric service ■ Identified lead - role identified in job plan and appraised ■ Policy and pathway of care available	6a, 6b, 20, 22, 25
31	Transition is properly planned, and a named key worker appointed for each child. The named worker should support the young person for the time defined in relevant legislation, or a minimum of 6 months - before and after transition (the exact length of time should be negotiated with the young person). The named key worker will also collaborate with other professionals. The patient is involved in the planning and delivery of their own care – and is asked on a regular basis how they would like their parents or carers to be involved.	■ Operational policy for paediatric service ■ Audit of effectiveness ■ Named key worker ■ Evidence of child / parent involved in care plan	6a, 6b, 20, 22, 25, 58
32	As part of the transition plan, the child and family are provided with relevant information that will help the child to achieve independence. The transition plan will also include information on how the child will be supported to develop and sustain social, leisure and recreational networks.	■ Information available is on file ■ Evidence in transition plans	58
33	There is a shared protocol between children's and adult services, which is a genuinely shared arrangement and is properly implemented.	■ Operational policy for paediatric service ■ Shared protocol available ■ Evidence of patient involvement in plans on audit	6a, 6b, 22, 58

E. CLINICAL SERVICES		EVIDENCE	REF
Maintaining a safe environment for CYP is essential at all times. This includes the physical environment, the staff who work within it, and safe systems and processes that support staff and protect patients and the public. Adults and children are segregated as much as possible, or arrangements have been made that recognise the needs of children.			
Physical environment			
34	All environments where children and young people are seen accommodate the needs of CYP and accompanying families, and comply with children-friendly environments. This includes audio-visual separation from adults as well as consideration of: ■ Security issues ■ Availability of food and drink ■ Breastfeeding areas ■ Hygienic, safe play facilities ■ Access to quieter waiting and treatment areas, and age-appropriate games, music or films ■ Parental overnight stay, if required	■ Audit of all areas where CYP receive care against criteria ■ Site visit including involvement of CYP as part of panel	4, 6a, 6b, 9, 20, 22, 26, 51, 57
Segregation			
35	Child-friendly accommodation in a purpose-designed children's ward or department is provided. This includes a defined area (including surgery and recovery) that can be separated off to provide privacy for young people and their visitors. Children are seen in designated children's clinics. Where this is not possible, there is consideration for the needs of children and carers. The needs of young people are considered on children's wards or where nursed separately in adolescent wards. In all services, young people-friendly environments are provided for inpatients and outpatients. There should be resources for older age groups, away from small children. Where specific facilities for young people are not available they should be accommodated in a separate area in a children's ward	■ Site visit ■ Example of evidence of measures in place working towards designated clinics where volume is sufficient ■ PREMs are monitored	6a, 6b, 22, 26, 27, 51,57
Equipment			
36	All medical equipment is the correct size and specification for use on children. Its design is tailored to meet the different needs at different ages and stages of development.	■ Site visit	5, 6a, 6b, 7
Paediatrics | General			
37	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	■ Operational policy for paediatric service ■ Rotas	4, 23
38	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade (ST4 or above) or consultant rota within four hours of admission.	■ Operational policy for paediatric service ■ Audit of notes	9
39	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	■ Operational policy for paediatric service ■ Audit of notes	4
40	A consultant paediatrician is to be present and readily available in the hospital to cover extended day working (up until 10pm), seven days a week.	■ Operational policy for paediatric service ■ Rota and job plans	4

E. CLINICAL SERVICES		EVIDENCE	REF
Paediatrics | General			
41	All children admitted as an emergency are seen and reviewed by a consultant during twice daily ward rounds enabling assessment by responsible consultant within 12 hours of admission or 14 hours of arrival at hospital.	■ Operational policy for paediatric service ■ Rota and job plans ■ Audit of notes	4
42	At least two medical handovers on the inpatient ward in every 24 hours are led by a paediatric consultant. Handovers are undertaken by senior clinicians using a recognised handover tool (SBAR).	■ Operational policy for paediatric service ■ Rota and job plans ■ Handover policy, training process and documentation ■ Lead clinician identified	4, 6a, 6b, 9, 12, 22
43	A named consultant paediatrician is available for liaison and immediate advice and cover, including telephone advice, for acute problems for all specialties, including surgery, and for primary care practitioners.	■ Operational policy for paediatric service ■ Evidenced by a description of services, rotas and availability	4, 6a, 6b, 9
44	Each service has a children's nurse lead (e.g. surgery, A&E, outpatients).	■ Operational policy for paediatric service ■ Management structure, job description	6
45	Prompt screening of all complex needs inpatients takes place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary assessment is undertaken within 14 hours and a treatment or management plan is in place within 24 hours. (Note: The MDT will vary by specialty, but as a minimum will include nursing, medicine, pharmacy, physiotherapy, occupational therapy, speech and language therapy and psychology.)	■ Operational policy for paediatric service ■ Audit of notes demonstrating discharge date and time from referral to assessment, and plan in place ■ Measures to assess physical, psychological and emotional needs	4, 12, 20
46	All Short Stay Paediatric Assessment units have access to a consultant paediatrician (or equivalent) opinion throughout all the hours they are open.	■ Operational policy for paediatric service ■ Rota and job plans	4, 9
Paediatrics | Patient safety			
Safe prescribing			
47	There are systems in place to minimise prescription and drug administration errors. The capacity of individual clinicians to prescribe and administer safely based on the outcomes from the prescribing assessment are assessed and support is in place for individuals who have not demonstrated competence in this area. There is awareness of using off-label and unlicensed drugs for children. Copies of the British National Formulary for Children (or equivalent) are available in all clinical areas. Nursing best practice recommends that children's nurses have yearly drug calculation tests (refer to NMC guidance).	■ Operational policy for paediatric service ■ BNF and BNF for children available across trust ■ RCPCH paediatric prescribing tool in use for all newly recruited prescribers ■ Evidence of processes in place to minimise errors and to spread learning	1, 28, 29, 30

E. CLINICAL SERVICES		EVIDENCE	REF
Emergency department			
All environments where children and young people are seen to conform to all published standards relating to the care of children and young people in Emergency Care settings.			
48	An initial clinical assessment and triage, which includes a pain score, occurs within 15 minutes of arrival by a practitioner with appropriate competencies. A system of prioritisation for full assessment is in place if the waiting time exceeds 15 minutes.	■ Emergency Department operational policy	22, 51, 59
49	Analgesia is dispensed for moderate and severe pain within 20 minutes of arrival.	■ Emergency Department operational policy ■ Audit of drug charts	51
50	All EDs to have a named paediatric consultant with designated responsibility for paediatric care in the ED either on-site or via networked arrangements that include robust, safe transfer protocols for the acutely unwell child. All EDs are to appoint a consultant with sub-specialty training in paediatric emergency medicine. EDs to have in place clear protocols for the involvement of an on-site paediatric team.	■ Operational policy for paediatric service ■ Emergency Department operational policy ■ Policies/ rotas/ management structure	4, 57
51	EDs and all hospital based settings seeing paediatric emergencies to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.	■ Emergency Department operational policy	57
52	Individualised management plans are accessible for children who attend the emergency care setting with priority access (e.g. 'emergency passport/card holder').	■ Emergency Department operational policy ■ Passports available and protocol re priority access	51
53	Systems are in place to identify children and young people who attend frequently or who are not brought to follow up and have potential safeguarding concerns.	■ Emergency Department operational policy ■ Protocol in place – audit of number of CYP triggering alerts	51
54	Emergency departments have in place clear protocols for the involvement of an on-site paediatric team.	■ Operational policy for paediatric service ■ Emergency Department operational policy	4, 23
55	Inpatient specialist referrals are made on the same day as the decision to refer, and patients are seen by the specialist within 24 hours (or one hour for high risk patients, defined as having a risk of mortality greater than 10 per cent, or where a patient is unstable and not responding to treatment as expected).	■ Operational policy for paediatric service ■ Audit of notes	12
56	Emergency doctors and nurses are familiar with local guidelines, and know when and how to access more senior or specialist advice promptly for children.	■ Emergency Department operational policy for paediatric service ■ Site visit confirms that guidelines available and staff know how to access	20, 51
57	One clinical cubicle or trolley space (at minimum) is dedicated to children for every 5,000 child attendances annually.	■ Observe during visit	51

E. CLINICAL SERVICES		EVIDENCE	REF
Emergency department			
58	Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Patient ED episode to be completed including initial psychiatric assessment within four hours of arrival.	■ Operational policy relating to mental health services within paediatric acute care	57
59	Staff should have access to both telephone consultation and an on-site response from a dedicated pool of CAMHS professionals known to the local hospital during and out of hours. Staff should not be in the position of having to speak with someone who has no direct knowledge of their clinical environment and staffing skills in dealing with psychiatric emergency and managing the risk of young people who self-harm or attempt suicide.	■ Operational policy relating to mental health services within paediatric acute care	57
Management of acutely ill children			
These standards relate activities which must be delivered in any hospital which admits acutely ill children and focus on the commoner acute presentations and clinical scenarios that require an enhanced level of observation, monitoring and intervention than can be safely delivered on a normal ward.			
60	All hospitals admitting children should be able to deliver Basic Critical Care (CC) in a defined critical care area, classified as a Level 1 Paediatric Critical Care Unit	■ Operational policy for the acutely unwell child, including transfers and the management of life saving intervention	59
61	On any site that sees children (inpatients, short stay, ED, UCC, OPD, theatres) there are arrangements and a policy in place for the immediate care of critically ill patients. The policy covers: ■ Recognition, stabilisation and consultant level involvement in management of the critically ill or injured child ■ Roles and responsibilities of the paediatric resuscitation team ■ Provision of training for the paediatric resuscitation team ■ Links with local retrieval service ■ Debriefing of incidents where the resuscitation team is activated for involving critically ill or injured children ■ Audit of team effectiveness	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions ■ Policy in place ■ Log of training in management of critically ill child ■ Audit of paediatric resuscitation team response ■ Evidence of debriefing	4, 5, 6a, 6b, 23, 32, 50, 59
62	Protocols for management of critically ill children are in place and include the management of: ■ Acute respiratory/cardiovascular emergencies ■ Metabolic emergencies ■ Neurological emergencies ■ Trauma ■ Sepsis ■ Poisoning ■ Major burns	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions ■ Paediatric anaesthetic rota ■ Evidence of paediatric resuscitation skills in the anaesthetic team	4, 5, 6a, 6b, 17, 18,59

E. CLINICAL SERVICES		EVIDENCE	REF
Management of acutely ill children			
63	Local guidelines identify roles and responsibilities of the MDT for management of the acutely unwell child, including anaesthetic services. ■ There is involvement of anaesthetics in the management of the critically ill child in centres without an on-site PICU for intubation, resuscitation and initiation of intensive care before the arrival of the retrieval team or direct transfer to PICU. ■ All anaesthetists maintain paediatric resuscitation skills unless they work in a unit which does not have open access for children.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions ■ Staff rota, including paediatric anaesthetic rota ■ Evidence of paediatric resuscitation skills in the anaesthetic team	4, 5, 23, 59
Transfer (within and between hospitals)			
64	Trust boards are accountable for having and monitoring robust and cohesive policies for inter-hospital transfer (IHT), including repatriations, that encompass the agreed pan London standards. All hospitals to be linked into networks for clinically indicated IHTs.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions	33, 34, 53
65	There is a designated consultant with responsibility for transfers who provides and updates a written policy for emergency transfers of intubated children.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions ■ Job plan	4, 5, 33, 34
66	Protocols are in use covering transfer of seriously ill children within the hospital (for example, to or from imaging or theatre). The protocol specifies the escort arrangements and equipment required.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions	32
67	The responsible consultant is directly involved and in attendance at the hospital for the initial management and referral of all children requiring critical care. The paediatric intensive care retrieval consultant is responsible for all decisions regarding transfer and admission to intensive care.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions	4, 5, 33, 34
68	The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the responsibility of the sending consultant until the child reaches the receiving hospital. All required records and results of investigations must be available for the receiving hospital. The consultant at receiving hospital is responsible for providing advice on management of the child if required.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions	4, 5, 33, 34, 53

E.	CLINICAL SERVICES	EVIDENCE	REF
69	A policy and arrangements are in place for situations where retrieval is clinically inappropriate or time-critical and may introduce unsafe delay. These include severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. Arrangements cover: ■ Advice from the retrieval service or lead PIC centre. ■ Contact details of relevant specialists where additional advice may be required (for example, neurosurgeons). ■ Escort team of one nurse and one appropriately trained doctor. ■ Training and experience of transferring critically ill children. ■ Team indemnity for escort team. ■ Drugs and equipment including portable monitors, transfer equipment (including a portable ventilator) are readily available. ■ Ambulance service contact information, vehicle specification (road ambulance) and response times. ■ Arrangements for emergency transport with a local ambulance service and the air ambulance arrangements for ensuring restraint of children, equipment and staff during transfer.	■ Operational policy for the management of the acutely unwell child, including transfers and management of life saving interventions ■ Written protocol agreed with retrieval service covering the local population. ■ Rotas for fulfilling designated roles ■ Training in transport of the critically ill child including familiarisation with equipment ■ Audit of transfers out including timeliness, level of staff transferring child, transport-associated incidents and outcome	4, 5, 33, 34
70	Formal arrangements are in place with regional paediatric intensive care unit for acceptance and transfer of critically ill children including retrieval. Arrangements are in place covering when the lead PIC centre is full or the retrieval team cannot function.	■ Written policy ■ Transfer audit	6a, 6b, 32
Surgery			
Emergency surgery is normally undertaken in a hospital with comprehensive paediatric facilities (as described in general paediatrics section above). Units will need to demonstrate attainment of standards as either a core or advanced provider of surgical care as described in the Children's Surgical Network standards that are to be published shortly.			
71	Standards for children's surgery are met, including the use of the WHO surgical checklist for all appropriate procedures. Clear policies are in place to ensure appropriate and safe theatre scheduling and implementation of clear policies for starvation times.	■ Operational policy for surgery and anaesthesia in children and young people including theatre scheduling, starvation times, provision of lead consultant ■ Audit of use of surgical checklist ■ Theatre schedule	4, 6a, 6b
72	All patients admitted as emergencies are discussed with the responsible consultant if surgery is being considered.	■ Operational policy for surgery and anaesthesia in children and young people ■ Audits of documentation	4

E.	CLINICAL SERVICES	EVIDENCE	REF
73	Where children are admitted with surgical problems they are jointly managed by teams with competencies in both surgical and paediatric care, which includes having a named consultant paediatrician and a named consultant surgeon.	■ Operational policy for surgery and anaesthesia in children and young people ■ Rotas ■ Audit of records	4. 5. 6a, 6b
74	Staff should be aware of the need to establish pregnancy in older CYP prior to surgery.	■ Operational policy for surgery and anaesthesia in children and young people	6b
75	Surgical emergencies are undertaken on planned lists. The date, time and decision maker is documented clearly. Reasons for any delay/change of plan is recorded. Only life or limb saving procedures are carried out at night (as per NCEPOD classifications).	■ Operational policy for surgery and anaesthesia in children and young people ■ Audit of patient records	4, 5, 6a, 6b, 34
76	Elective surgery for children is scheduled on a dedicated children's theatre list. Where this is not possible, cases are scheduled with consideration for the needs of children and carers.	■ Operational policy for surgery and anaesthesia in children and young people ■ Example lists	5, 6a, 6b
77	The trust/network has a policy to support surgeons and anaesthetists undertaking lifesaving interventions in children who cannot be transferred or who cannot wait until a designated surgeon is available.	■ Operational policy for surgery and anaesthesia in children and young people includes management of life saving intervention in these circumstances	6a, 6b
78	All hospitals admitting emergency surgery patients have access to a fully paediatric- competent staffed emergency theatre, and a consultant surgeon and a consultant anaesthetist with appropriate paediatric competencies are on site within 30 minutes at any time of the day or night.	■ Operational policy for surgery and anaesthesia in children and young people ■ Rotas and environment ■ Evidence of competency in appraisals	4, 6a, 6b
79	In the period immediately after anaesthesia the child should be managed in a recovery ward or post-anaesthesia care unit on a one-to-one basis by designated staff with up-to-date basic paediatric resuscitation training	■ Operational policy for surgery and anaesthesia in children and young people	57
Day case surgery			
80	Children's surgery is provided on a day case basis wherever practical. The lower age limit for day surgery depends on the facilities and experience of staff and the medical condition of the infant. Ex-preterm babies are not considered for day surgery unless they are medically fit and have reached 60 weeks post-conceptual age.	■ Operational policy for surgery and anaesthesia in children and young people ■ Example day case lists / regular audit ■ Rotas	5, 6a, 6b, 23
81	A minimum of two registered children's nurses are present in day surgical areas.	■ Operational policy for surgery and anaesthesia in children and young people ■ Rotas	5, 6a, 6b,7
82	Parents and children are provided with good quality pre-operative information which includes fasting guidelines and what to do if the child becomes unwell before the operation date.	■ Operational policy for surgery and anaesthesia in children and young people ■ Information provided to patients and carers	5, 6a, 6b, 23

E. CLINICAL SERVICES		EVIDENCE	REF
Anaesthesia			
Children's surgical networks emergency service standards define core providers as 3+ years and advanced providers as all ages. Trusts are able to provide anaesthetic support according to designated level.			
83	In all centres admitting children, one consultant is appointed as lead consultant for paediatric anaesthesia. Typically they might undertake at least one paediatric list each week, and will be responsible for co-ordinating and overseeing anaesthetic services for children, with particular reference to teaching and training, audit, equipment, guidelines, pain management, sedation and resuscitation.	■ Operational policy for surgery and anaesthesia in children and young people ■ Rotas and job plans ■ Name of identified lead	5
84	The service is led and organised by consultants who maintain competencies to anaesthetise children and young people.	■ Operational policy for surgery and anaesthesia in children and young people ■ Evidenced by CPD	5
85	The anaesthetist must at all times have a dedicated assistant who maintains competencies in the peri-operative care of children and young people.	■ Operational policy for surgery and anaesthesia in children and young people ■ Evidenced by CPD	5
86	In all centres where children are admitted for surgery, ensure all protocols for sedation are signed off within apropriate level of clinical guidance structure.	■ Operational policy for surgery and anaesthesia in children and young people	6b
Pain			
87	There is an adequately staffed and resourced acute pain service that covers the needs of children. Pain relief is an explicit part of young people's care, and staff are trained in pain management.	■ Operational policy for pain assessment and management in children ■ Pain relief as explicit part of standard operating procedures for dealing with young people	5, 20, 35
88	Each hospital site providing services for children has 24-hour access to pharmacy, biochemistry, haematology, microbiology, pathology and imaging.	■ Evidenced by service outlines, hours of opening and policies ■ Operational policy for imaging and pathology	23

F. CLINICAL SUPPORT SERVICES		EVIDENCE	REF
Allied health professionals			
AHPs include physiotherapists, dieticians, occupational therapists, speech and language therapists, play therapists and technicians.			
89	Physiotherapy and services from other AHPs are available seven days a week to support the care of children.	■ Rotas	4, 23
90	There is seven day working to support early rehabilitation post injury and post operatively.	■ Rotas	12
Imaging and pathology			
91	Children and young people who are inpatients must have scheduled seven day access to diagnostic services: ■ X-ray ■ Ultrasound ■ Computerised tomography (CT) ■ Echocardiography ■ Endoscopy ■ Pathology ■ Bronchoscopy ■ Magnetic resonance imaging (MRI) Where services are not available on site, there are robust transfer protocols agreed within a network.	■ Operational policy for imaging and pathology services including network arrangements ■ Service-specific competency frameworks are in place for this service including relevant professional body guidance on professional standards	4, 6a, 6b, 12, 22, 36, 37, 38, 39, 50
92	Consultant-directed diagnostic tests and completed reports are available seven days a week to support clinical decision making: ■ Critical - Imaging and reporting within 1 hour ■ Urgent - Imaging and reporting within 12 hours ■ Non-urgent (all) - Within 24 hours When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours	■ Operational policy for imaging and pathology services including directory of imaging for CYP available within trust	4, 6a, 6b, 12, 22, 37, 38, 40, 57
93	Where a service is not available on-site (e.g. interventional imaging / endoscopy or MRI), clear patient pathways are in place between providers. The service agrees imaging modalities and their specific indications. Where specific investigations are not available in a particular trust, clear, robust and timely arrangements are made for them to be carried out in other centres as agreed by commissioners.	■ Directory of imaging for CYP available within trust ■ Evidence of network arrangements for imaging / investigations not available within trusts	12, 22

G.	CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES WITHIN ACUTE PAEDIATRIC CARE	EVIDENCE	REF
The mental health of the child, young person and their family is an integral part of all children's services, not overlooked when a physical health disorder takes priority.			
94	Emergency departments have a single point of access for child and adolescent mental health (CAMHS), or adult mental health services with paediatric competencies for children over 12 years old. Referrals are available 24 hours a day, seven days a week, with a maximum response time of 30 minutes (this can be remotely).	■ Evidence of pathway and referral times	4, 6a, 6b, 12
95	There are robust arrangements between fully staffed emergency departments and urgent care centres. This includes protocols covering consultation and transfer of cases.	■ Evidence of pathway and arrangements for transfer	6a, 6b, 12
96	Mental health assessment takes place within 12 hours of call to assess physical, psychological and emotional needs.	■ Audit of notes demonstrates time from referral to assessment and plan in place	4
97	All services offer information and advice to help young people and their families make decisions regarding psychological wellbeing and mental health support needs based on informed consent. The service makes attempts to provide flexibility about involving other people in the assessment and treatment process.	■ Records of service provided and service user responses recorded	20
98	Appropriate staff receive training and appraisal to ensure they are: able to talk to young people about mental health issues; knowledgeable about a range of support and treatment options; clear about who they are able to help; able to recognise and facilitate informed consent; and able to recognise and respond to different therapeutic needs such as those relating to gender, sexual orientation and age.	■ Staff training and assessment procedures	20
99	A clear referral path is identified for young people with emotional and mental health concerns. The pathway may include specialised CAMHS input, including psychiatry, psychology, individual and family psychotherapy, social work, and CAMHS-trained and experienced nurses.	■ Evidence of clear referral pathway	20, 41
H.	**OUTPATIENTS**		
100	Children are seen in designated children's clinics. Where this is not possible, cases are scheduled with consideration for the needs of children and carers. Clinics providing care for young people have a young people-friendly environment. Where this is not possible, cases are scheduled with consideration of the needs of young people.	■ Example of ethics / evidence of measures in place working towards designated clinics where volume is sufficient/PREMs are monitored	6a, 6b, 27
I.	**LONG TERM CONDITIONS**		
101	Local pathways are in place for all children with chronic disease and long term conditions (e.g. asthma, diabetes, cystic fibrosis, gastroenterology, neurology, epilepsy), paediatric surgery, and access to psychological support and CAMHS. Written care plans need to be in place for appropriate community/ primary care professionals – school nurse, GP, continuing healthcare nurse, occupational therapist, physiotherapist, speech and language therapist, community paediatrician and CAMHS.	■ Evidence of pathways and plans	NICE
102	All services with a best practice tariff (BPT) comply with BPT standards (e.g. epilepsy and diabetes).	■ Evidence of achieving tariff outcomes	42, 43

J. CHILDREN WITH COMPLEX NEEDS		EVIDENCE	REF
The care and support of young people with complex needs are considered in the context of their cognitive ability and chronological age.			
103	All patients under 13 years old who are admitted acutely are continually assessed using a recognised Paediatric Early Warning System (PEWS) tool. All patients over 13 years old are continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol is used for all patients. Consultant involvement for patients considered 'high risk' is within one hour.	■ Operational policy for paediatric service ■ Evidence of training in NEWS / PEWS for all clinical staff ■ Audit of NEWS / PEWS usage ■ Evidence of use of NEWS competency based escalation trigger protocol	4, 12, 37
K. SAFEGUARDING CHILDREN AND YOUNG PEOPLE			
All staff working with babies, children and young people must be trained in the safeguarding of CYP.			
104	All staff involved in the care of CYP must comply with the appropriate standards set for safeguarding and London child protection procedures. This includes The London Child Sexual Exploitation (CSE) Operating Protocol that sets out how agencies will identify and address CSE to provide a standard and consistent response across London.	■ Operational policy for paediatric service ■ Safeguarding training programmes ■ Audit of staff understanding ■ Evidence of named safeguarding doctor and nurse	8, 44, 45
105	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.	■ Operational policy for paediatric service ■ Evidenced by job plans and audit or written records	4, 9
106	Healthcare systems and processes, policies and procedures are in place to support healthcare professionals' practice in safeguarding children: ■ Safeguarding children policies and procedures are in place and available organisation-wide. ■ Policies include how to raise concerns about work colleagues. ■ A designated or named nurse and doctor for safeguarding children are appointed, whose contact details are known throughout the organisation and whose role and responsibilities are clearly outlined. ■ A single, integrated child health record system, including mechanisms for obtaining records of previous attendances / admissions from other organisations, is in place to prevent miscommunication and gaps in shared information. ■ All children's nurses and other nurses who come into contact with children and young people have undertaken initial training and annual updating in safeguarding CYP, commensurate with the nurse's position and level of responsibilities. ■ All those involved in child protection work have access to supervision and support from managers on a frequent and regular basis.	■ Operational policy for paediatric service ■ Evidence of policy and protocols available across all departments which states name and contact for designated leads and staff know how to raise concerns ■ Evidence of single record in use ■ Evidence of training and CPD ■ Evidence of access to supervision for staff	4, 5, 6a, 6b, 9, 22, 23, 27, 45

L. GENERAL SERVICES FOR CHILDREN AND YOUNG PEOPLE		EVIDENCE	REF
107	Consultations routinely promote healthy lifestyles, including assessment of long term health needs, including: ■ Systematic approach to obesity (e.g. growth measurement, calculation of BMI) ■ Assessment of CYP and family for smoking, alcohol and drugs and access to smoking cessation and other support services	■ Evidence to ensure taken place and documented	20, 46
Play and education			
Play and education are important components of any CYP service, and are incorporated into clinical service seven days a week.			
108	Emergency departments seeing more than 16,000 children per year employ play specialists at peak times or have access to a play specialist service.	■ Operational policy for paediatric service	51
109	Support services (such as translation, play therapy and support, and health visitors) are available. All children and young people have access to play and hobby materials, and there is experienced staff (play specialist) to oversee play activities	■ Operational policy for paediatric service ■ Play therapist available on rota ■ Appropriate materials visualised	5, 6a, 6b, 7, 23
School and education			
110	During admission to hospital, children and young people are able to continue with their school activities and education to the degree that they are able to or wish to.	■ Operational policy for paediatric service ■ Description of services offered	7, 22
M. WORKFORCE PLANNING			
General			
111	Networks encourage rotation of staff and shared learning opportunities to develop and maintain skills across the care pathway.	■ Operational policy for paediatric service ■ Evidence of staff rotation	5, 6
Nursing			
Organisations follow a nationally (or internationally) accepted, objective and rational formula for staffing and skill mix in all environments where children are seen and cared for. This formula, along with the senior children's nurse's professional judgement, determine the specialty-specific nurse to patient ratios which underpin the delivery of safe and effective high quality care.[1]			
112	Nurses in hospital-based settings working with children and young people are trained in children's nursing, with additional training for specialist services or roles. Units seeing paediatric emergencies, emergency departments and short stay patients have a minimum of two paediatric trained nurses on duty at all times (at least one of whom is band 6 or above), with appropriate skills and competencies for the emergency area. Paediatric inpatient ward areas have a minimum of two paediatric trained nurses on duty at all times, and paediatric-trained nurses make up 90 per cent of the total establishment of qualified nursing numbers.	■ Operational policy for paediatric service ■ Evidence of training available and staff CPD ■ Rotas and skill mix	4, 7

1 A senior qualified children's nurse is a nurse that holds a children's nursing qualification, plus a master's degree in an appropriate health/social care related subject, with a minimum of five years' full time experience in uninterrupted clinical practice. The expectation is that this post would be at a minimum of band 8a, dependent on the full scope and remit of the position, in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification.

M. WORKFORCE PLANNING		EVIDENCE	REF
113	In children's hospitals and children's units, or hospitals having more than two dedicated wards for children and young people, there is a minimum of one registered children's nurse who is suitably qualified and experienced in mental health issues, and has undertaken an educational programme in child and adolescent mental health. This nurse provides a lead role with these patients, and supports other staff in undertaking their care.	■ Operational policy for paediatric service ■ Evidence of records of training, registration and CPD	19, 23
114	There is a minimum registered (70 per cent) to unregistered (30 per cent) staff, although the precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children's intensive care, specialist, and in many cases general children's units.	■ Operational policy for paediatric service ■ Evidenced through rotas	7
115	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave.	■ Operational policy for paediatric service ■ Evidenced through staffing numbers	7
116	A recognised patient dependency scoring tool is used to provide an evidence base for daily adjustments in staffing levels.	■ Operational policy for paediatric service ■ Evidence of tool available and staff trained to use it	7, 39
117	The shift supervisor in each clinical area is supernumerary to ensure effective management, training and supervision of staff.	■ Operational policy for paediatric service ■ Evidenced by rota	7
118	When children and young people are inpatients on an adult ward, a designated senior children's nurse is available 24 hours per day to provide advice on nursing care and support. Registered children's nurses are deployed to work alongside nurses in the adult environment to provide care for CYP.	■ Operational policy for paediatric service ■ Evidenced by rota	19
Medical			
119	All general acute paediatric rotas are made up of at least 10 WTEs, all of whom are EWTD compliant.	■ Operational policy for paediatric service ■ Audit of rotas	9
N. EDUCATION AND TRAINING			
120	Unregistered staff have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks.[2]	■ Operational policy for paediatric service ■ Evidence of training programme for the care certificate for CYP	8, 39, 55, 56
121	Organisations have the responsibility to ensure that staff involved in the care of children and young people receive appropriate child-specific training provided in a supportive environment and have access to appraisal and undertake ongoing training.	■ Operational policy for paediatric service ■ Evidence of CPD and appraisal system in place	4, 6a, 6b, 55, 56
122	Members of staff routinely receive inter-disciplinary training on the issues of confidentiality and consent and issues pertaining to seeing young people without a parent/carer present. Inter-disciplinary training is undertaken in line with local safeguarding children arrangements to ensure that approaches to safeguarding are in line with Working Together to Safeguard Children.	■ Operational policy for paediatric service ■ Training presentations and materials on confidentiality issues provided	6a, 6b, 20, 23, 47, 48

2 Unregistered staff are those who are not qualified and on a professional register (eg healthcare assistant, physio assistant, etc)

N. EDUCATION AND TRAINING		EVIDENCE	REF
Basic life support and advanced life support			
123	At least one nurse per shift in each clinical area (ward/department) is trained in APLS / EPLS, depending on the service need.	■ Evidence in rotas	7, 12
124	All staff working in facilities where children present are trained in paediatric basic life support. Emergency department nursing staff are PILS/PLS or equivalent trained. Senior trainees and consultants in emergency medicine, paediatrics and anaesthetics dealing with acutely unwell children are trained to an appropriate level dependent on role.	■ Operational policy for paediatric service ■ Evidence of CPD	6a, 6b
125	All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis.	■ Evidence in records of training and CPD	4
Major incident planning for children and young people			
126	All healthcare organisations ensure planning for children is included in major incident plans and are involved routinely in appropriate major incident exercises.	■ Evidence in plans	6a, 6b
127	Children may be involved in a significant incident or emergency, either as casualties or as members of families or groups caught up in the event. Plans need to reflect procedures for dealing with paediatric casualties arising either directly or indirectly from an incident. Counselling is available to CYP and families after any event.	■ Evidence in plans	49, 51

Appendix

Revisions to the London Acute Care Standards for Children and Young People (April 2015)

Standard		Relating to	Comment
1; para 1	It is recommended that each trust with services for CYP has a named executive board member with board level responsibility, covering all aspects of care for CYP aged 0-18 years and for the care of young people up to the age of 25 with more complex needs. This should include responsibility for quality, safety and safeguarding of these children and young people.	A. Institutional commitment: infrastructure; involvement of Trust board	Additional wording: and for the care of young people up to the age of 25 with more complex needs
2	The trust has operational policies in place agreed by the trust board for the following: ■ Paediatric service ■ Management of the acutely unwell child, including transfers and management of life saving intervention ■ Surgery and anaesthesia in children and young people, including management of life saving intervention in these circumstances ■ Imaging and pathology services ■ Mental Health services within paediatric acute care ■ Emergency Department ■ Pain assessment and management of pain in children ■ Transition to adult services ■ Safeguarding	A. Institutional commitment: infrastructure; involvement of Trust board	Addition of four operational policies: ■ Mental Health services within paediatric acute care ■ Emergency Department ■ Pain assessment and management of pain in children ■ Transition to adult services
29	■ Systems are in place to ensure safe discharge and transfer between providers including: ■ All admitted CYP have discharge planning and an estimated discharge date as part of their management plan as soon as possible, and no later than 24 hours post admission. ■ The primary care team/GP is informed of discharge within agreed timescale of each attendance (including community nursing teams, health visitor and school nurse). ■ Information is provided to GP and community teams electronically within 24 hours of discharge. ■ Clear written information and advice are provided to families which includes what to do, when and where to access further care if necessary, along with clear instructions on follow up and arrangements in case of post-operative emergency at home. This includes telephone advice. ■ Post discharge there is liaison between the acute and community services, and community children's nurses are available to provide support to patients and family that require it	D. Integration and care coordination: Discharge/care planning	Addition of: Post discharge there is liaison between the acute and community services, and community children's nurses are available to provide support to patients and family that require it

Appendix

Standard		Relating to	Comment
31	Transition is properly planned, and a named key worker appointed for each child. The named worker should support the young person for the time defined in relevant legislation, or a minimum of 6 months - before and after transfer (the exact length of time should be negotiated with the young person). The named key worker will also collaborate with other professionals. The patient is involved in the planning and delivery of their own care – and is asked on a regular basis how they would like their parents or carers to be involved	D. Integration and care coordination: Discharge/care planning	Highlighted addition reflects NICE guidelines [NG43]: Transition from children's to adults' services for young people using health or social care services http://bit.ly/222c8Qc
32	As part of the transition plan, the child and family are provided with relevant information that will help the child to achieve independence. The transition plan will also include information on how the child will be supported to develop and sustain social, leisure and recreational networks.	D. Integration and care coordination: Discharge/care planning	New standard; reflecting NICE guidelines [NG43]: Transition from children's to adults' services for young people using health or social care services http://bit.ly/222c8Qc
50	All EDs to have a named paediatric consultant with designated responsibility for paediatric care in the ED either on-site or via networked arrangements that include robust, safe transfer protocols for the acutely unwell child. All EDs are to appoint a consultant with sub-specialty training in paediatric emergency medicine. EDs to have in place clear protocols for the involvement of an on-site paediatric team.	E. Clinical Services: Emergency Department	New standard; reflecting: Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications http://bit.ly/1qJvsEi Replaces the original Standard 50 (April 2015)
51	EDs and all hospital based settings seeing paediatric emergencies to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.	E. Clinical Services: Emergency Department	New standard; reflecting: Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications http://bit.ly/1qJvsEi
59	Staff should have access to both telephone consultation and an on-site response from a dedicated pool of CAMHS professionals known to the local hospital during and out of hours. Staff should not be in the position of having to speak with someone who has no direct knowledge of their clinical environment and staffing skills in dealing with psychiatric emergency and managing the risk of young people who self-harm or attempt suicide.	E. Clinical Services: Emergency Department	New standard; reflecting: Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications http://bit.ly/1qJvsEi
58	Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Patient ED episode to be completed including initial psychiatric assessment within four hours of arrival.	E. Clinical Services: Emergency Department	New standard; reflecting: Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications http://bit.ly/1qJvsEi

Standard		Relating to	Comment
60	All hospitals admitting children should be able to deliver Basic Critical Care (CC) in a defined critical care area, classified as a Level 1 Paediatric Critical Care Unit (PCCU).	E. Clinical Services: Management of the acutely unwell child	New standard; reflecting: Healthy London Partnership, Children and Young People's programme: Paediatric Critical Care (Level 1 and 2) High Dependency Care Standards http://bit.ly/1QwK26T
68	The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the responsibility of the sending consultant until the child reaches the receiving hospital. All required records and results of investigations must be available for the receiving hospital. The consultant at receiving hospital is responsible for providing advice on management of the child if required.	E. Clinical Services: Transfers within and between hospitals	Highlighted text reflects Standards for non-specialist emergency surgical care of children (November 2015) http://bit.ly/1S51Yet
74	Staff should be aware of the need to establish pregnancy in young people prior to surgery.	E. Clinical Services: Surgery	New standard: reflecting Standards for non-specialist emergency surgical care of children (November 2015) http://bit.ly/1S51Yet
79	In the period immediately after anaesthesia the child should be managed in a recovery ward or post-anaesthesia care unit on a one-to-one basis by designated staff with up-to-date basic paediatric resuscitation training.	E. Clinical Services: Surgery	New standard: reflecting Standards for non-specialist emergency surgical care of children (November 2015) http://bit.ly/1S51Yet
86	In all centres where children are admitted for surgery, ensure all protocols for sedation are signed off within apropriate level of clinical guidance structure.	E. Clinical Services: Anaesthesia	New standard: reflecting Standards for non-specialist emergency surgical care of children (November 2015) http://bit.ly/1S51Yet
92	Consultant-directed diagnostic tests and completed reporting are available seven days a week to support clinical decision making: ■ Critical - Imaging and reporting within 1 hour ■ Urgent - Imaging and reporting within 12 hours ■ Non-urgent (all) - Within 24 hours When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	D. Clinical Support Services: Imaging and pathology	Highlighted text reflects: Healthy London Partnership, Urgent and Emergency Care programme: Urgent and Emergency Care Facilities and System Specifications http://bit.ly/1qJvsEi
101	Local pathways are in place for all children with chronic disease and long-term conditions (e.g. asthma, diabetes, cystic fibrosis, gastroenterology, neurology, epilepsy), paediatric surgery, and access to psychological support and CAMHS. Written care plans need to be in place for appropriate community/primary care professionals – school nurse, GP, continuing healthcare nurse, occupational therapist, physiotherapist, speech and language therapist, community paediatrician and CAMHS.	J. Long-term conditions	Addition of asthma to list of long-term conditions

Appendix

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Appendix

Glossary

A&E	Accident and emergency
AOMRC	Academy of Medical Royal Colleges
APLS	Advanced paediatric life support
BAPN	British Association for Perinatal Medicine
BPT	Best practice tariff
CAMHS	Child and adolescent mental health services
CEM	College of Emergency Medicine
CDOP	Child death overview panels
CHIMAT	Child and Maternal Health Observatory
CPD	Continuing professional development
CQC	Care Quality Commission
CYP	Children and young people
DH	Department of Health
ED	Emergency department
EWTD	European working time directive
EPLS	European paediatric life support
GMC	General Medical Council
GP	General practitioner
HDU	High dependency unit
HLP	Healthy London Partnership
HMG	Her Majesty's Government
LCSB	Local children's safeguarding board
M and M	Mortality and morbidity meeting
MDT	Multi disciplinary team
NEWS	National early warning system
NHSE	NHS England
NCEPOD	National confidential enquiry into patient outcome and death
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NRLS	National reporting and learning system
OPD	Outpatient department
OT	Occupational therapy
PCC	Paediatric critical care
PEWS	Paediatric early warning system
PICS	Paediatric Intensive Care Society

PROMS	Patient reported outcomes measures
PREMS	Patient reported experience measures
PICU	Paediatric intensive care unit
PT	Physiotherapy
RCA	Royal College of Anaesthetists
RCN	Royal College of Nursing
RCS	Royal College of Surgeons
RCPCH	Royal College of Paediatrics and Child Health
SALT	Speech and language therapy
SBAR	Situation, background, assessment, recommendation
SCN	Strategic clinical network
SCR	Serious case review
SHMI	Summary hospital-level mortality indicator
SI	Serious incident
STEIS	Strategic Executive Information System
SSPAU	Short stay paediatric assessment unit
TARN	Trauma and Audit Research Network
TOR	Terms of reference
UCC	Urgent care centre
WTE	Whole time equivalent

Appendix

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