Facing the Future: Standards for children and young people in emergency care

Executive summary

Published October 2025

RCPCH
Royal College of Paediatrics and Child Health
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Facing the Future: Standards for children and young people in emergency care

Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care

Representative bodies:

Association of Paediatric Emergency Medicine
Joint Royal Colleges Ambulance Liaison Committee
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

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Introduction

This is the 5th edition of Facing the Future: Standards for Children and Young People in Emergency Care. The document sets out clear standards of care which are intended to act as a tool and evidence-based resource for healthcare professionals, managers, providers, commissioners and regulators to help ensure the effective design and delivery of high-quality paediatric emergency care services. At a time when continuing financial constraints make service development challenging, this standards document aims to support the efforts of hard-working frontline paediatric emergency care staff. It strikes the right balance between aspiring to provide the best possible care for each individual child and young person (CYP), whilst remaining pragmatic and locally deliverable.

This document has been revised using the combined experience and expertise of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care and followed a structured revision process. The process included stakeholder consultation, rapid evidence reviews, and collaborative drafting and editing. Feedback from a wide range of professionals and organisations was integrated to ensure the standards remain relevant, evidence-informed, and fit for purpose.

The document presents 82 standards across 13 chapters and builds on the success of previous versions, which have shaped paediatric emergency care over the past 25 years. It reaffirms and reiterates those standards that have come to form a well-established baseline of organisational and clinical paediatric emergency care practice, whilst refreshing and updating others in line with new guidance to address emerging challenges since the 2018 edition. The document introduces a brand-new chapter on health inequalities and improvement, which highlights health inequalities as avoidable, unfair, and systematic differences between groups, and positions the ED as a key place to empower CYP and families with health promotion. It additionally has a greater focus on the needs of adolescents/ those aged 16 – 18 within the ED.

The following pages present the executive summary list of the standards listed within the updated document. Please refer to the full Facing the Future: Standards for Children and Young People in Emergency Care document for further information.

Summary

Complete list of standards for children and young people in emergency care

No.	Standard	
	Chapter 1: An integrated urgent and emergency care system	**Page**
1	UEC services for CYP are planned, commissioned and delivered through clinical networks using an integrated whole pathway approach	**21-27**
2	The care of CYP in UEC settings is planned and delivered using the RCPCH Facing the future: Standards for children and young people in emergency care to appropriately meet their needs	
3	Alternative care pathways are provided to ensure the UEC needs of CYP are met at the right time and in the right place to protect ED capacity and reduce the risk of ED crowding	
4	All UEC services review the attendances of CYP separately from adults to allow the informed planning of future service and workforce provision to accurately meet demand	
5	ED and hospital escalation policies should be in place to respond to surges in patient activity and ED crowding	
	Chapter 2: Environment in paediatric emergency care settings	
6	UEC settings are designed to accommodate the needs of CYP, and those of their parents/carers and families. The design approach should aspire to excellence and facilitate best clinical practice with specific provision for adolescents, CYP with complex needs, mental health conditions and/or who are neurodivergent. The design process should be shaped in collaboration with CYP and their parents/carers	**28-33**
7	The design and configuration of UEC settings should reflect planned operational service and patient flow models, with sufficient capacity to cope with anticipated numbers of CYP attenders and additional flexibility to manage surges in patient activity	
8	In EDs seeing adult and paediatric patients, it is essential that the design and layout of the department are such that the needs of both groups of patients are equitably served	
	Chapter 3: Workforce and training	
9	All EDs treating CYP must include PEM consultants within their consultant workforce with dedicated clinical and non-clinical time allocated to paediatric emergency care	**34-44**
10	All EDs treating CYP must have at least two registered children's nurses on each shift, and at least one nurse with an advanced paediatric life support qualification. For larger units this role should be filled by a Band 6 (or above) registered children's nurse	
11	All EDs treating CYP must always have clinical staff on duty with the necessary paediatric competencies for the safe immediate assessment and management of critically ill and injured CYP	
12	All EDs treating CYP should have dedicated education, training and governance sessions focused on the care of CYP for all ED staff. In mixed departments, this could form part of an integrated education programme	
13	All EDs treating CYP should actively support the professional development, acquisition of leadership skills and career progression of their paediatric emergency nursing workforce	

14	All EDs treating CYP must have the medical and nursing staff on each shift that is adequate to cope with 80% of predicted maximum demand	**34-44**
15	Working practices for PEM consultants need to reflect the high intensity nature of their clinical work, and should adopt the recommended mitigations for job planning and rota design	
16	All EDs treating CYP should have a lead for staff wellbeing, with appropriate time allocated for this role	
17	All EDs treating CYP must employ (or have access to) a play specialist with additional training and experience in supporting CYP with complex needs. Availability of the play service should cover hours of peak demand, including evenings and weekends	
Chapter 4: Management of the sick or injured child		
18	CYP should be easily visible in the waiting area of all UEC settings and a formal triage process should be undertaken within 15 minutes of arrival to determine priority category. This assessment should be supplemented by a full record of vital signs, a weight and a pain score for all CYP presenting with a medical illness or significant trauma	**45-53**
19	Sufficient staff resource and space should be allocated for triage areas to cope with fluctuations in, rather than average, demand (both in terms of patient numbers and time taken to complete triage). A rapid system of prioritisation must be implemented when the wait time to triage exceeds 15 minutes	
20	All CYP who are streamed away from a UEC setting must have been assessed by a regulated health care professional with the necessary paediatric competencies and experience in paediatric initial assessment	
21	CYP with abnormal vital signs at triage should have these repeated within 60 minutes, or in keeping with locally agreed PEWS and triage category. (For example, an unwell looking patient with abnormal observations and a high triage category should be in the resuscitation area or Majors on continuous monitoring, whereas a well looking patient with a fever and mild tachycardia and a lower triage category could reasonably wait up to an hour to have their observations repeated)	
22	All EDs treating CYP should use an appropriate Paediatric Early Warning System (PEWS) for recording patient observations	
23	All EDs should have policies in place for the immediate escalation of care for a critically ill or injured CYP	
24	All EDs treating CYP must have an appropriate set of clinical guidelines and range of drugs and paediatric equipment available	
25	Analgesia must be dispensed for CYP with moderate and severe pain within 20 minutes of arrival in the ED and their pain score reassessed and acted upon within 60 minutes	
26	All EDs treating CYP should have agreed policies in place for specific patient categories who require review by a senior decision maker prior to discharge	
Chapter 5: Safeguarding in emergency care settings		
27	All health professionals who regularly care for CYP should have up-to-date safeguarding training and competencies in line with the *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*	**54-61**

28	All UEC settings should have clinical guidelines in place for safeguarding CYP, which are bespoke to the individual local inter-agency arrangements and which incorporate the relevant statutory guidance	
29	All EDs have in place a lead consultant and a lead nurse with shared responsibility for child protection within the department	
30	Information from a Child Protection Plan/Register is available to relevant professionals working in UEC settings 24/7, preferably through shared secure electronic information systems, or alternatively via a duty social worker	
31	All staff working in UEC settings have access to safeguarding advice 24/7 from a paediatrician with adequate child protection expertise	
32	Systems are in place to identify and respond appropriately to CYP who attend UEC settings frequently	
33	CYP whose presentation indicates that they are at risk of significant harm (e.g. those on a Child Protection Plan/Register, non-mobile infants presenting with injuries such as bruising, burns or fractures, or perplexing presentations including potential Fabricated or Induced Illness) must be reviewed by a senior decision maker with the necessary competencies prior to discharge	**54-61**
34	GPs and other relevant members of the community child health team (midwife/ health visitor/school nurse/children's community nurse/named social worker/ specialists) are informed of the attendance of a CYP (including care leavers) at a UEC setting within an agreed time frame	
35	Standard operating procedures are in place to review cases where CYP leave, are taken or abscond from a UEC setting before being seen or before discharge, or who do not attend follow up, with escalation in real-time to the appropriate multi-agency child protection team where concerns have not been immediately addressed or mitigated. Escalation policies should be in place with CPS and police colleagues	
36	All UEC settings seeing CYP where safeguarding issues have been identified should have access to child protection peer review sessions run in accordance with the RCPCH Child Protection Peer review guidance	
Chapter 6: Mental health		
37	All CYP presenting to the ED should have a developmentally appropriate assessment of their immediate emotional and mental health needs	
38	An assessment of immediate risk should be done for all CYP presenting in mental health crisis to inform decisions about where and how a CYP is treated within the ED, and this process should commence on arrival. This should include consideration as to how closely the CYP should be monitored and documentation of any safeguarding risks	
39	A safe and appropriate space must be available for CYP presenting in mental health crisis, which should accommodate parents and carers and allow suitable supervision by ED staff	**62-69**
40	ED staff must have access to mental health records and individual crisis care plans for CYP who present with mental health concerns or in mental health crisis via CAMHS liaison	
41	A mental health practitioner should be available for telephone advice for CYP in the ED 24/7 and/or is able to attend the ED for direct patient assessment when required	

42	All CYP presenting to the ED following self-harm or in mental health crisis, must have a face-to-face developmentally appropriate biopsychosocial assessment of their immediate emotional and mental health needs within one hour of referral, undertaken by a mental health professional from a paediatric liaison psychiatry/ mental health crisis team experienced in carrying out such an assessment	**62-69**
43	A clear system is in place with allied agencies to escalate the care of CYP who present with a mental health concern who • require Tier 3(+)/Tier 4 inpatient care, or • who do not require Tier 4 inpatient care but whose parent/carer feels unable to take them home	
44	There is a clear pre-defined pathway for CYP on a section 136 order for an identified place of safety to meet their medical and mental health needs, as outlined in a local place of safety policy	
45	ED staff receive training in how to communicate effectively, assess risk and immediately manage CYP with mental health needs and in supporting their family/ carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity/competence[i]	
46	ED guidelines are in place for the management of an acutely distressed or agitated CYP incorporating the use of de-escalation strategies, reasonable environmental adjustments and chemical/physical restraint for those who are at risk of harm to themselves or others	
47	When CYP require access to a mental health inpatient bed, but there is a delay of >4 hours, they should be looked after in a suitable paediatric clinical location with appropriate inpatient facilities, regular CAMHS reviews and physically present registered mental health and paediatric nurse support	
Chapter 7: Children and young people with complex needs		
48	There should be systems in place in the ED to identify/ flag CYP with complex needs. ED staff should ask to see the CYP's Emergency Care Plan (ECP), where one exists, which should be held electronically wherever possible to signpost to relevant information, such as the possible requirement for early senior assessment or the need for reasonable adjustments. Systems should be in place to enable CYP with complex needs to be prioritised, following a needs-based approach, when seen in the ED	**70-76**
49	When treating a CYP with complex needs in the ED, systems should be in place to enable escalation for review by a senior decision maker	
50	EDs should have accessible information and communication tools available for CYP with complex needs and/or communication differences including, but not limited to, pain assessment tools, access to an interpreter (including for sign language) and visual aids such as social stories and easy-read information leaflets	

i Healthcare professionals who have contact with CYP who have self-harmed should understand how to apply the principles of:
-Children Act 1988
-Children and families Act 2014
-Mental Health Act 2007
(With regards to safeguarding children, capacity to consent/ Gillick Competence, Scope of Parental Responsibility & use of Section 5(2) or 5(4) based on ED setting/ Paediatric ward setting) [NICE. 2022. Guidelines: Self-harm: assessment, management and preventing recurrence. Available at: https://www.nice.org.uk/guidance/ng225)

51	EDs should have a lead professional for CYP with complex needs and access to advice and support from a Learning Disability Liaison Nurse	**70-76**
52	ED staff must have appropriate training in the management of CYP with complex needs	
53	Information about a CYP with complex needs attending ED should be shared with the relevant professionals involved, including the GP and lead clinician, where one exists. Links should also be established with the community children's nursing team to ensure effective follow-up care and support	
Chapter 8: Health improvement and health inequalities		
54	All EDs treating CYP should have resources and signposting for common public health issues, such as maintaining a healthy weight, oral health, vaccines and immunisation information (including targeting vaccine hesitancy) with any health promotion advice documented in the patient's notes	**77-84**
55	All EDs should provide relevant information on benefits and support for families who may be struggling financially	
56	All young people of secondary school age should undertake a biopsychosocial assessment in the ED (e.g. HEEADSSS or Not Just a Thought) with signposting to relevant resources including smoking, drugs, alcohol and sexual and mental health advice	
57	All EDs treating CYP should be able to refer relevant patients to a violence reduction service	
58	All EDs treating CYP should identify a lead professional for health promotion and public health, with dedicated time in their job plan, and health promotion and public health issues should be included in a department's teaching programme	
59	All EDs should have 24/7 access to interpreter services, including a BSL interpreter	
60	All EDs should have a guideline and pathway for CYPSAR (whether accompanied or unaccompanied)	
61	All EDs treating CYP should have access to written and electronic safety netting advice for common paediatric presentations in accessible formats and in a variety of languages. Safety netting advice given should be documented in the patient's notes	
Chapter 9: Major incidents involving children and young people		
62	CYP must be specifically included in the strategic and operational planning in preparation for, and response to, major incidents and business continuity arrangements. This should be in line with relevant national/regional structures and include adaptations for triage, clinical capacity and mental health support	**85-89**
63	All health care workers with a role in a major incident response must be involved in appropriate training and incident exercises	
64	EDs should have representation on pandemic planning groups	
Chapter 10: Safe transfers		
65	Each region has a Paediatric Critical Care Transport Service (PCCTS)	**90-94**
66	The regional PCCTS has a dedicated 24-hour critical care referral phone line providing clinical support and advice, and coordinating retrievals and transfers for critically ill or injured CYP	
67	Local hospital facilities have appropriate staff and equipment readily available for time-critical inter-hospital transfers	

68	Any staff involved in the stabilisation and transfer of CYP should be appropriately trained in this area, as per local agreements	**90-94**
69	Parents and families of children transferred between hospitals are given practical help and information detailing their child's transfer destination	
70	All EDs should have appropriate guidelines and checklists in place to safely manage intra-hospital patient transfers	
71	All EDs should test their transfer systems annually, using simulated patient transfer exercises involving all appropriate members of the multidisciplinary team, with regional PCCTS support	
Chapter 11: Death of a child or young person		
72	All EDs caring for CYP up to the age of 18 have an agreed policy in place for responding to the unexpected death of a CYP as per their national guidelines	**95-99**
73	CYP who have died outside of the hospital setting are transported to a hospital with paediatric facilities[ii]	
74	All EDs caring for CYP provide training for staff on how to support parents/carers in response to the unexpected death of a CYP and have processes in place to support the staff involved	
75	Before leaving the ED, bereaved parents/carers should be provided with an information pack including: • The legal requirement for registering the death • Any involvement of the designated paediatrician, the coroner or the police and the child death review process • Details of the hospital bereavement support service with arrangements for an appointment within the next 24-48 hours	
76	All EDs should cooperate with the designated paediatrician and the child death review process to ensure any learning is shared between agencies for all CYP up to the age of 18	
Chapter 12: Information system and quality care indicators		
77	All health care practitioners treating CYP in the UEC network have access to information systems that provide the required demographic episode-related information and functionality	**100-104**
78	All EDs treating CYP collect the necessary Emergency Care Data Set (ECDS) and performance data that can be used to improve services locally and to benchmark performance nationally	
79	All EDs treating CYP should adhere to the Emergency Care Discharge Standard	
80	All health organisations providing UEC to CYP must collaborate with national or regional information programmes to disaggregate data for CYP to involve and inform the needs of patients, clinicians, managers and service planners/commissioners in developing emergency care information systems	
Chapter 13: Research for paediatric emergency care		
81	All EDs that are Paediatric Major Trauma Centres, affiliated to a university or have at least one dedicated PEM consultant should be in good standing with PERUKI	**105-107**
82	All ED's treating CYP should review published research and consider how it can inform quality improvement or be implemented in practice	

ii *If a family would prefer their infant to remain at home, the attending ambulance and police team should liaise with the paediatric team at the hospital and with the police investigating officer to plan an appropriate response. In such circumstances, a GP, certified member of ambulance staff or forensic medical examiner may confirm that the infant has died.

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ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

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The 5th Edition of the Facing the Future: Standards for children and young people in emergency care is planned to undergo review after 5 years. Therefore, the content of document will be considered for review in 2030.

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