Facing the Future:

Standards for acute general paediatric services

Revised 2015

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

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Foreword

Five years on from the publication of the *Facing the Future* standards we continue to experience significant challenges in delivering sustainable, high quality care to all children.

The workforce is doing an incredible job under increasingly difficult circumstances but, with huge demands on services and cuts in funding and recruitment problems, we cannot continue under the current structure and configuration of services.

We know that the UK performs poorly on child mortality and there continues to be unwarranted variation in provision across the country. This combined with the findings of the *Back to Facing the Future* audit and the coroners' reports received by the College, demonstrate that we cannot be complacent.

It is essential that paediatrics is a 24 hours a day, seven days a week specialty; we need our most experienced doctors present at the busiest times. It is on this basis that we are making changes to the *Facing the Future* standards.

We recognise that the revised standards will need a greater degree of consultant presence, and we know that we cannot achieve these changes alone within the current configuration of services and staffing levels. For this reason the College continues to take a clear position on service reconfiguration and redesign. We are committed to working with members, services, commissioners, planners and inspectorates to support them to implement the changes needed to meet these standards.

We also have to be prepared to re-examine the way in which we deliver care; providing more care in the community, more primary care healthcare professionals trained in child health and more paediatricians operating outside the hospital setting. I encourage you to read these standards in conjunction with the *Standards for Children and Young People in Emergency Care Settings* and the new *Facing the Future: Together for Child Health* standards which focus on keeping children out of hospital, caring for them in the community, wherever safe and possible to do so.

It will be difficult but I have no doubt that if implemented these standards will have a hugely positive effect on the quality of healthcare services for children in UK.

Dr Hilary Cass
President, Royal College of Paediatrics and Child Health

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Executive summary

In 2010, the Royal College of Paediatrics and Child Health (RCPCH) published the *Facing the Future* standards setting out ten key requirements to deliver high quality, safe and sustainable acute general paediatric services. The *Back to Facing the Future* audit in 2013 demonstrated that the standards are being used on a daily basis by paediatricians, both to reflect on their own practice, and to advocate for better care for children.

It was always intended that *Facing the Future* would remain live and flexible to changes in the health system and, five years on from their original publication, the RCPCH has conducted a review of the standards and agreed to amend four of them. In summary the changes to the standards are:

- Standard one (previously standard six): This standard remains, in the short term, as consultant presence at self-defined peak times. However, the direction of travel and the RCPCH's five year strategic plan is that there should be a consultant present for at least 12 hours a day, seven days a week.
- Standard three (previously standard two): This standard has been changed to specify that all children admitted with an acute medical problem are seen by a consultant paediatrician within 14 hours of admission (revised from 24 hours in the original standard).
- Standard four (previously standard five): This standard has been changed to specify that there are two consultant led handovers every 24 hours (revised from one handover every 24 hours in the original standard).
- Standard eight: The explanatory guidance of this standard has been changed to recognise that there are a growing number of ways of achieving safe, experienced cover and that, where there are rotas comprised of different staff groups, the whole time equivalent on the rota may be modified.

The RCPCH believes that these standards will bring a level of consistency to what is currently quite a variable pattern of practice. The intention is to ensure that every child is seen in a timely manner by a suitably experienced doctor. Increased consultant presence will not only improve the quality and safety of care but will also provide additional training opportunities, though care is needed to ensure that this is not at the cost of limiting the development of independent decision making skills.

The standards cannot be met with the current workforce and the current number of inpatient units. The five key recommendations made in the original report are even more crucial with these revisions to the standards:

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Facing the Future represents a standard of care which children and their parents and carers can expect from the doctors looking after them. We hope that paediatricians will see them not just as standards to strive toward, but as a lever to continue to improve the safety, quality and sustainability of services.

1. Background

In 2010, the RCPCH developed and published *Facing the Future: Standards for Paediatric Services*[1] which outlined ten minimum standards for acute, general paediatric care. These are set out in the box below.

Facing the Future Standards 2010

1. 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 or consultant rota within four hours of admission.
2. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.
3. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
4. All short stay paediatric assessment units have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
7. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
8. All general acute paediatric rotas are made up of at least ten whole time equivalents, all of whom are European Working Time Directive compliant.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. 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) available to provide immediate advice and subsequent assessment, if necessary, for children and young people 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.

This was followed, in 2011, by *Facing the Future: A Review of Paediatric Services*[2], which provided workforce and service provision modelling around the implications of the standards. Five key interlocking recommendations were made:

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

In 2013, the RCPCH completed an audit of the standards and published *Back to Facing the Future: An audit of acute paediatric service standards in the UK*[3]. The audit found that most of the time, most of the standards are being met across the UK and that they were being used by paediatricians, both to reflect on their own practice, and also to advocate for better care for children with respect to planning, commissioning and providing paediatric services. *Back to Facing the Future* also identified a number of areas within the standards which required further clarification and where compliance (particularly for some of the small print) was poor.

In 2014 coroners' reports on four children were sent to the RCPCH for a response. The coroners outlined concerns around the lack of timely consultant assessment and management of these children and the lack of consultant supervision of paediatric trainees.

It was always intended that *Facing the Future* would remain live and flexible to the changes in the health system. Five years on from their original publication and in light of national health policy changes, the findings of the audit and the coroners' reports, the RCPCH has conducted a review of the standards and agreed revisions to four of the standards to improve the quality and safety of care delivered.

2. Review of the standards

The review of the standards was led by a small RCPCH working group in consultation with key RCPCH committees. The members of the Working Group were:

Dr Carol Ewing (Clinical Lead)	Vice President, Health Policy, RCPCH
Emily Arkell	Head of Policy, RCPCH
Professor Anne Greenough	Vice President, Science and Research, RCPCH
Isobel Howe	Policy Lead, RCPCH
Dr Dan Lumsden	Chair, Trainees Committee, RCPCH
Martin McColgan	Workforce Information Manager, RCPCH
Dr David Shortland	Past Vice President, Health Services, RCPCH
Rachel Winch	Workforce Projects Coordinator, RCPCH

The standards were reviewed based on the methodology set out in the RCPCH's Rapid Development Process and the following key steps were undertaken:

1. The *Back to Facing the Future* audit was used to identify areas of poor compliance or where clarification was needed.
2. A literature review was carried out and a summary of the current standards set by other Royal Colleges and standard settings bodies produced.
3. A focus session was held at the RCPCH Annual Conference in April 2014 to discuss the proposed changes to the standards with the membership. The revision of the standards was also discussed with the RCPCH: Executive Committee, Welsh Executive Committee, Scottish Executive Committee, Ireland Executive Committee, Paediatricians in Medical Management Committee, Intercollegiate Emergency Standards Committee, Child Protection Standing Committee, Informatics for Quality Committee, Clinical Standards Committee, Youth Advisory Panel, Parent and Carers Group, Trainees Committee, Staff, Associate Specialists and Specialty Doctors Committee, General Paediatrics Special Interest Group, General Paediatrics College Speciality Advisory Committee and Remote and Rural Special Interest Group.
4. Following a discussion at the July 2014 RCPCH Council meeting, further consultation with RCPCH members and key stakeholders on the feasibility and impact of implementation of the revised standards was carried out. Council Regional Representatives were asked to consult with their local members and members were also able to respond individually online through the RCPCH website.
5. Based on the feedback from the consultation and the current financial climate within the NHS, the proposed changes to the standards were revised and agreed by the RCPCH Council in November 2014.

3. Revised service standards

The following chapter sets out ten key service standards for acute, general paediatric services. They are underpinned by three key principles:

- Consultants are responsible and accountable for the children under their care.
- Children must be seen by the correct person, with the appropriate skills, as soon as possible.
- There must be sufficient staff across all rotas to deliver the standards.

The standards are first listed overleaf and then an explanatory guide to each one is provided in the next chapter.

Throughout the standards the term 'child' or 'children' is used to refer to infants, children and young people under the age of 18 across the UK.

Facing the Future Standards 2015

1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.

3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.

4. At least two medical handovers every 24 hours are led by a consultant paediatrician*.

5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.

6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.

7. All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.

8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

10. All children, 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) who is available 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 by a written report.

* or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota

4. Explanatory guide to the standards

Standard one

A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

Peak times will depend on local patterns of service activity and patient referral, arrival and discharge.

For many units we would expect that this would mean that a consultant paediatrician* is present and readily available in the hospital for a minimum of 12 hours a day, seven days a week i.e. with extended evening working until 10pm. Over the next five years we would expect all units to implement this model of increased (12 hour) consultant presence.

An individual consultant's working day should not exceed 12 hours and must be compliant with the UK Working Time Regulations and European Working Time Directive. Extended working until 10pm will require more than one consultant shift per day, with overlap to enable handover.

Standard two

Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.

Standards two and three apply to acute rather than elective admissions. They refer to admissions to the paediatric department or the paediatric assessment unit not attendance at the emergency department (although the paediatric assessment unit may be located in the emergency department or in the paediatric department). The admission time is taken to be the official time of admission to the paediatric department or the paediatric assessment unit rather than the time of presentation to the emergency department or the time of referral to the paediatric department.

The RCPCH would expect healthcare professionals on the tier two (middle grade) paediatric rota to be those who are judged to have achieved level one competencies in the RCPCH *Framework of Competencies*. This would normally mean those working in posts at ST4 or above.

In units where there are just two tiers of medical cover this will not be possible and the consultant* should be resident when it is judged that any member of the tier one (junior) rota does not have the basic competencies of recognising a sick child and being able to initiate treatment for paediatric emergencies.

Standard three

Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.

The RCPCH recognises that implementation of this standard will need consultant led ward rounds twice a day, seven days a week. The RCPCH believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality of care[4, 5].

The consultant should be aware of the possible impact of this standard on the training of paediatric trainees and steps should be taken to use clinical assessments/interventions in supporting trainees to develop decision making skills. For example, the trainee can carry out an assessment supervised by the consultant.

Standard four

At least two medical handovers every 24 hours are led by a consultant paediatrician*.

The handover must include all children referred to the paediatric team, regardless of whether a decision to admit was made or not, and should include a system risk assessment. The system risk assessment should include: a local risk monitoring system for each patient at handover (paediatric early warning scores or equivalent); noting the number and complexity of high dependency unit cases; the level of service activity; awareness of incoming referrals; staffing levels; and staffing competencies (both medical and nursing).

Consultant presence during the handover also provides a training opportunity; the trainee should be encouraged to lead the handover whilst supervised by the consultant.

Standard five

Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.

This standard concerns all children referred for an urgent paediatric opinion, whether the source of that referral is general practice or the emergency department.

The RCPCH would expect all children to be seen by healthcare professionals with appropriate expertise. As a minimum the RCPCH would expect all cases to be discussed with a senior doctor or nurse as specified above. This standard would preclude a less experienced doctor who has not achieved level one competencies in paediatrics sending a child home without that child being discussed with a more senior colleague.

Standard six

Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.

All paediatric assessment units should have paediatric consultants* available for advice – this may be by phone or in person.

Standard seven

All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.

With the introduction of the Working Time Regulations continuity of care has become a significant problem for inpatient care. The RCPCH believes that the most appropriate system to mitigate the effect of new working practices is to adopt a consultant of the week system in which the consultant has no other clinical duties during that week but is fully available for the management of acute admissions.

Standard eight

All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

The RCPCH recognises that there are a growing number of ways of achieving safe experienced cover. Where there are rotas comprised of different staff groups, the Whole Time Equivalent (WTE) on the rota may be modified. For example, the additional direct clinical care programmed activities (PAs) available from three additional consultants (with an average two supporting programmed activities (SPAs)) would be broadly equivalent to the time available from four trainees. Thus a rota of six trainees and three WTE consultants is feasible although it must ensure that, in line with RCPCH guidance[6], no consultant on a 10 PA contract should have more than four PAs (3.2 after prospective cover) dedicated to resident shift working. This type of work should be part of a phased career plan and units should undertake team job planning to support this.

Including staff, associate specialist or speciality (SAS) doctors on a rota allows slightly more flexibility for these models because the contract requirement for SPAs is less than for consultants; a rota would be possible with two additional WTE SAS doctors and seven trainees. Rota designs should ensure job plans of SAS doctors support their career development.

Where they possess the appropriate competencies, advanced children's nurse practitioners can also be substituted for trainee doctors on paediatric rotas[7, 8].

Standard nine

Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

With increasing centralisation of specialist care and in order to facilitate appropriate care closer to the child's home, it is imperative that local paediatricians have access to appropriate specialist advice in a timely manner, at least if unnecessary referrals and admissions are to be avoided. This standard aims to ensure that the local paediatrician, whether based in the community, a paediatric assessment unit or an inpatient unit, can access the specialist opinion that is needed when faced with acute problems in children with complex and specialist needs. It is optimal if such advice is provided as part of a managed clinical network which encompasses all of the local secondary care providers.

Before specialist advice is requested, the case should be discussed with the local paediatric consultant*. Similarly any specialist advice provided should also be discussed with the specialist consultant*.

This standard does not apply when the presenting problem is not an emergency, nor does it apply to referrals from non-paediatricians who should, in the first instance, seek the advice of their local paediatric service.

Standard ten

All children, 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) who is available 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 by a written report.

Standard ten aims to ensure that any child presenting with child protection concerns is appropriately assessed at an appropriate time by a competent paediatrician. This service must be available to all units on a 24/7 basis. As with all clinical presentations, the timing of the assessment is determined by the presentation and, in child protection, the likelihood of finding and collecting forensic evidence.

An initial strategy discussion (with interagency colleagues) must take place in accordance with local safeguarding policies, as soon as practical and usually within two hours. Depending upon the needs of the child (clinical, forensic and safety) the child must be assessed and an opinion provided (which may be provisional depending upon further investigations and discussion) usually within 12 hours of presentation where there are recent injuries. The written medical document should be available within three days.

Specialist paediatric and forensic opinion should be available to all units within four hours for all acute sexual assaults and all unexpected child deaths. Paediatricians should act as the 'single point of contact' for children's social care departments to articulate the concerns of the medical professionals involved with the family. They should attend initial and review conferences whenever there is likely to be a discussion of the interpretation of medical views or findings.

5. Rationale for the changes to the standards

Since the publication of the *Facing the Future* standards in 2010 much has happened both in the NHS and the wider economic and social environment in which it operates. England has seen the implementation of the *Health and Social Care Act 2012*, which has significantly reshaped the NHS, and the 'Nicholson challenge' of £20 billion in efficiency savings. Services across the UK continue to operate in a tight economic climate and with an increasing number of emergency department attendances and hospital admissions. The *NHS England Five Year Forward View*[9] published in October 2014 recognised that action would be needed on three fronts: demand, efficiency and funding.

The UK is also facing considerable challenges in continuing to provide safe, sustainable services that meet the needs of children and their families. Workforce pressures, medical and technological advances and children's changing needs and expectations all contribute to the need for change.

The *Francis report* into the tragic events at Mid Staffordshire NHS Foundation Trust[10] and the *Berwick review into patient safety*[11] serve as a reminder of the fundamental culture and values that sit at the heart of the NHS and what can go wrong if key standards are not met. The *Keogh Review*[12] on seven day working highlighted that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. The move to seven day services was backed by the Academy of Medical Royal Colleges with the recognition that early senior involvement improves decision making which results in better care and resource use, patients and carers are reassured and there is less changing direction – overall a better healthcare experience.

The RCPCH has both a responsibility and the ability to influence the quality of the paediatric service that is provided for children in the UK and this is critically important in the light of the significant funding pressures on healthcare services.

The standards published in *Facing the Future* are intended to provide a framework in which quality and safety are maintained in the system. Currently, a large proportion of the healthcare provided to children in the UK is by paediatric trainees. These 'service' (as opposed to 'training') activities are integral to the current running of the NHS but, as trainee numbers reduce, future models of care will require a move away from this dependency (for example, resident consultant shifts and increasing numbers of advanced paediatric nurse practitioners).

The RCPCH accepts that implementation of the revised *Facing the Future* standards will necessitate a greater degree of consultant presence than has been the case but believes that these standards will bring a level of consistency to what is currently quite a variable pattern of practice – children should receive the same high quality, safe service regardless of the day of the week or time of day. Increased consultant presence helps to maintain the consistency of the service and allows more support to be provided to less experienced trainees as and when necessary. Increased consultant presence also acts as a safeguard even for experienced trainees, providing them with increased access to oversight and supervision without this having to be asked for.

The potential impact of these standards on the training of paediatricians has been discussed in detail with the RCPCH Trainees Committee, which is supportive of the proposed changes. Their view is that increased consultant presence will not only improve the quality and safety of care but will also provide additional training opportunities, for example, during handovers and ward rounds, though care is needed to ensure that this is not at the cost of limiting the development of independent decision making skills. Within the standards we have highlighted the importance of consultants considering, discussing and meeting the training needs of paediatric trainees.

Standards two, five, six, seven, nine and ten have not been significantly changed (although the order has been altered).

Rationale for changes to standard one

A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

The *Back to Facing the Future* audit highlighted that the standards are not being met as regularly at weekends and evenings as they are between the hours of 9am and 5pm. This means that at times of peak activity, when you would expect the standard of service to be at its most robust, the most senior and experienced staff are not always present. This is consistent with recent news stories concerning the service that the NHS provides during evenings and weekends and with the findings of the Keogh Review on seven day working[13].

We fully recognise the pressures on acute paediatricians within the current structure and configuration of services, but believe that the audit demonstrates that we have to be prepared to re-examine the way in which we deliver care. It is essential that paediatric services are organised around the child's needs and that paediatrics is a 24 hours a day, seven days a week specialty.

In 2010 the *Temple report*[14] concluded that consultant-delivered care was the only viable model for the future of medical care in the UK. There were a number of reasons for this but most importantly the simple fact that consultants 'make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality'. The *Temple report* defines consultant delivered care as '24 hour presence, or ready availability' and it is this model of service that underpins many of the *Facing the Future* service standards.

The debate over consultant delivered care has progressed since 2010, with the Academy of Medical Royal Colleges (AoMRC) publishing *The Benefits of Consultant-Delivered Care*[15] in 2012. This looked at the available evidence and concluded that a consultant led service resulted in rapid and appropriate decision making, improved outcomes for patients, more efficient use of resources, improved GP access to the opinion of a fully trained doctor, satisfied patient expectations of access to appropriate and skilled clinicians and information, and benefited the training of doctors.

In 2012, the RCPCH published *Consultant Delivered Care: An evaluation of new ways of working in paediatrics*[16]. The report concluded that children would receive better care if they had 24/7 access to a consultant or equivalent senior doctor and that the 'resident shift working consultant model is central'.

This standard has been moved to be the first of the *Facing the Future* standards, on the basis that increased consultant presence and availability is necessary to be able to deliver the rest of the standards.

The standard is designed to ensure that a consultant paediatrician is present at peak times with flexibility to take account of local patterns of activity. This standard will, in the short term, remain as consultant presence at self-defined peak times. However, the direction of travel and the RCPCH's five year strategic plan is that there should be a consultant present for at least 12 hours a day, seven days a week.

Rationale for changes to standard three

Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.

The *Back to Facing the Future* audit found that 87.7% of children admitted to a paediatric department with an acute medical problem were seen by a consultant paediatrician (or equivalent) within the first 24 hours of admission. However, the small print of the original standard recommended that if the most senior resident doctor is at ST3 level then the consultant review should take place within 12 hours of admission rather than 24 hours. In the vast majority of cases this recommendation was not observed and there was little difference between the time that a consultant would see a patient following examination by an ST3 or an ST4 or above. This was of significant concern to the Working Group and reflected the concerns in the Coroners' reports around the level of supervision by senior staff of the management of individual patients by trainees and the frequency of assessment by senior staff.

The AoMRC report on *Seven Day Consultant Present Care*[17] recommended that hospital patients could expect to 'be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway'. The RCPCH supports this recommendation and would argue that this is yet more acute in paediatrics, a specialty in which the patients are admitted for shorter periods, but whose condition is less predictable and more likely to deteriorate quickly. This can be coupled with an inability of the child to articulate their symptoms. Parents and carers expect, quite appropriately, to be able to speak to the consultant when their child is unwell and admitted to hospital.

The National Confidential Enquiry into Patient Outcome and Death report on *Emergency Admissions: a journey in the right direction*[18] also recommends that patients admitted as an emergency should be seen by a consultant at the earliest opportunity and ideally within 12 hours.

The NHS England Seven Days a Week Forum[19] set out in its 2013 standards that 'all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at the hospital'.

The standard has been changed to ensure that all children admitted with an acute medical problem are seen by a consultant paediatrician (or equivalent) within the first 14 hours of admission (rather than 24 hours as in the original standard).

The RCPCH recognises that implementation of this standard will need consultant led ward rounds twice a day, seven days a week. The RCPCH believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality of care[20, 21].

Findings from the audit indicate that 31% of admissions are already being seen by a consultant within 12 hours. 39% of admissions were not seen by a consultant within 12 hours (with another 22% being discharged in under 12 hours and 8% unknown). The standard has already been introduced for paediatric services in London[22] and the Royal College of Physicians[23] and Royal College of Surgeons[24] specify consultant review within 12 hours.

Rationale for changes to standard four

At least two medical handovers every 24 hours are led by a consultant paediatrician*.

The *Back to Facing the Future* audit found that 94.1% of units had at least one medical handover in every 24 hours led by a paediatric consultant (or equivalent). In many units this was performed as often as three times a day and included members of the senior nursing team to ensure the whole team was up to date. There was strong support for this system and many clinical directors and ward managers felt that an inclusive, well documented handover was the glue that held their service together.

Implementation of the European Working Time Directive (EWTD) and the UK Working Time Regulations (WTR) and the consequent transition to shift patterns of working have significantly reduced the continuity of care that trainee doctors used to provide and increased the number of clinical handovers between medical staff. However, the RCPCH's position[25] is that the EWTD and WTR are health and safety regulations which should be upheld both for the safety of staff and for their patients, and that the healthcare system should be designed to maintain the WTR.

There is a growing body of evidence that clinically significant information can be lost during the handover process, and that this can lead to adverse outcomes for patients[26, 27, 28, 29]. Consultant presence during the handover not only improves patient outcomes it also provides an excellent training opportunity[30].

This standard has been changed to specify that there must be at least two consultant led handovers every 24 hours (as opposed to one as in the original standard).

Rationale for changes to standard eight

All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

The AoMRC has stated that in order to protect adequate training time, as well as to cover for annual leave and recovery periods, ten Whole Time Equivalent (WTE) doctors in a rota are required[31]. It is possible to design rotas that are compliant with just eight staff and, in relation to neonatal medicine where there is less daytime outpatient activity this may be appropriate[32]. However, for general acute paediatrics, eight cell rotas inevitably result in the use of locums and can lead to less exposure to daytime training time, and therefore in practice are not sustainable or recommended. The RCPCH does not support trainees opting out of the WTR.

The standard itself has not been changed but the explanatory text has been updated to recognise the role of different staff groups on paediatric rotas.

6. Implementation of the standards

This revision of the *Facing the Future* standards, and particularly the change from 24 hours to 14 hours for children to be seen by a consultant, marks a move towards ensuring that paediatrics is a 24 hours a day, seven days a week specialty and that services are organised around the child with quick access to an expert opinion.

The RCPCH accepts that implementation of these standards will necessitate a greater degree of consultant presence than has been the case but believes that these standards will bring a level of consistency to what is currently quite a variable pattern of practice. The RCPCH believes that the direction of travel (over the next five years) is to implement 12 hour consultant presence, seven days a week.

These standards should complement a clinical director's assessment of the needs of their service. We want to support and prompt conversations with units that do not meet the standards and to facilitate discussions between neighbouring units on how the standards might be met by working as a bigger team in network configurations.

To deliver the revised standards, it is clear from the response to the consultation exercise that general acute consultant numbers would need to increase. The standards cannot be met across the UK with the current workforce and the current number of inpatient units and the five key interlocking messages in the original *Facing the Future* report are even more crucial with these revisions to the standards:

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Detailed modelling of the workforce needed to deliver the revised standards is available on the RCPCH website (www.rcpch.ac.uk/facingthefuture).

The RCPCH continues to call for a concentration of inpatient services on fewer sites, where it is clinically safe to do so, and for an increase in consultant numbers. The RCPCH has also been actively supporting the Royal College of General Practitioners' (RCGP) proposals to extend GP training to accommodate greater exposure to paediatrics and children's health.

The RCPCH cannot implement these standards alone and will require support and agreement from other NHS organisations. A detailed implementation plan is available on the RCPCH website (www.rcpch.ac.uk/facingthefuture) which sets out how the RCPCH will implement the standards by:

- Supporting and equipping members with the information and skills to influence at a local level
- Supporting services to implement the standards
- Encouraging services to work together in regional networks to implement the standards
- Continuing discussions and negotiation between the RCPCH and key stakeholders at a national policy level

7. Related work

Facing the Future Together for Child Health

This revision of the *Facing the Future* standards is part of a larger programme of work towards whole system change and the RCPCH continues to look at innovative models of service provision.

The RCPCH, working with the Royal College of General Practitioners and the Royal College of Nursing, is also simultaneously launching a new set of standards, *Facing the Future Together for Child Health*. These standards build on the *Facing the Future* standards, expanding them to acute care outside the hospital and look across the care pathway at how we can improve healthcare and outcomes for children. Focussing on the care of the acutely mild to moderately unwell child, they aim to ensure there is always high quality care and diagnosis early in the unscheduled care pathway and to reduce unnecessary attendances at emergency departments and admissions to hospital.

The two sets of standards should be considered together when developing service models and pathways of care across primary and secondary care services.

Visit www.rcpch.ac.uk/togetherforchildhealth

Outcome measures

Facing the Future has been successful at building consensus over the required service standards for acute paediatrics. However, there are currently no reliably evidenced outcomes for acute paediatric care, and so the standards were based upon expert opinion. The lack of evidence of successful outcomes resulting from service change makes it difficult to say for certain that service interventions are having a positive or negative effect.

It has always been the intention of the RCPCH to monitor the impact of the standards set out in *Facing the Future* to evaluate their efficacy in improving the care children receive. As a consequence the RCPCH has established a working group tasked with proposing outcome measures against which to benchmark services and to monitor the effect of service change. This Working Group is projected to make final recommendations in late 2015.

The aim of the Group is to reach consensus agreement regarding five to ten outcome measures for acute paediatric services which are relevant to patients and carers, to clinicians and to service planners and commissioners. In England, the measures will also be aligned with the NHS Outcomes Framework, with formal representation from the Children and Young People's Health Outcomes Forum on the Working Group.

Prior to the final publication of these standards the data collection will be piloted at selected centres to ensure the feasibility of standard measurements. Tools to support data collection at the local level will be included in the final report, with a key aim of the group being to limit the burden upon centres of additional data collection.

Visit www.rcpch.ac.uk/facingthefuture/outcomemeasures

Patient safety

The RCPCH is also actively involved in patient safety initiatives, for example, the Infant, Children and Young People's Patient Safety Expert Group hosted by NHS England which is developing a consistent paediatric early warning score and patient safety thermometers. The RCPCH has also developed links with and presented at a recent meeting of the Paediatric Collaborative in Northern Ireland, which aims to facilitate the provision of high quality, safe paediatric care to ensure the best outcomes for children. The Scottish Paediatric Safety Programme was established in 2009 and aims to support paediatric staff to improve the quality and safety of paediatric care.

Situation Awareness for Everyone (S.A.F.E) is a two year programme led by the RCPCH which is developing and trialling a suite of quality improvement techniques. It will trial models of care including the 'huddle' technique to encourage information sharing and to equip professionals with the skills to spot when a child's condition is deteriorating as well as prevent missed diagnosis.

Visit www.rcpch.ac.uk/safe

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Royal College of
Paediatrics and
Child Health

5-11 Theobalds Road, London, WC1X 8SH