



## Facing the Future Audit 2017:

*Facing the Future: Standards for acute general paediatric services*

*Facing the Future: Together for child health*

April 2018



These Standards were audited with involvement from &US Young Inspectors

For more information, and to meet the Facing the Future Superhero, please visit [www.rcpch.ac.uk/superhero](http://www.rcpch.ac.uk/superhero)

 **RCPCH**  
**&Us**

The voice of children,  
young people and  
families

# **Facing the Future Audit 2017**

## **An audit of**

*Facing the Future:*

*Standards for acute general  
paediatric services*

**and**

*Facing the Future:*

*Together for child health*

Published April 2018



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## Foreword

We are pleased to introduce a national audit of the first two sets of *Facing the Future standards: Standards for acute general paediatric services* and *Together for child health*. Data submitted by paediatric clinical directors across the UK has provided us with rich and vital evidence to help us understand how services are meeting standards and what impact they are having on the ground.

Delivering effective, safe and sustainable care for children at a time when there are significant financial pressures on health services and unprecedented demand is challenging for both health professionals and service planners. It is therefore essential as a College that we publish standards that we believe are right for children who require hospital inpatient, urgent or unscheduled care and it is also our responsibility to see that these standards are being met. We are committed to supporting paediatricians to develop services that can deliver care to the high standard that children and their families have the right to receive.

The report demonstrates many areas of improvement, but there is still a long road ahead to ensure that children are being cared for in the right place, at the right time and by a person with the necessary paediatric competence. We have been able to draw comparisons between audit data from the 2013 *Back to Facing the Future* report that has enabled us to see incremental improvements in consultant cover during peak hours and an excellent result in all services implementing a consultant of the week system with rotas that ensure children are discussed with an appropriately competent child health professional prior to discharge.

The audit has benefitted from site visits to paediatric services across the UK, for the first time with involvement from the &Us Young Inspectors Programme. These visits have provided crucial feedback to understand where barriers to progress are occurring and where we as a College have work to do to refine and improve our standards.

We cannot drive improvements in child health alone and this report calls for an overall investment in resource available to fund the workforce needed to implement standards. We are committed to supporting our members, service planners and health organisations to serve the interests of the children and families in our care.

**Professor Russell Viner**

President  
Royal College of Paediatrics and Child Health

**Dr David Shortland**

Chair, Facing the Future Audit Project Board  
Royal College of Paediatrics and Child Health

**Melissa Ashe**

Policy Lead  
Royal College of Paediatrics and  
Child Health

## Executive Summary

This audit reports UK performance on the RCPCH *Facing the Future: Standards for acute general paediatric services* and *Facing the Future: Together for child health* standards in June 2017. The RCPCH standards for acute general paediatrics were first published in 2010, audited in 2013 and updated in 2015. Where possible, comparison is made between the 2013 and 2017 audits to monitor progress. The *Together for child health* standards were published in 2015 and results from this initial audit will provide evidence to inform any necessary changes to the standards as well as providing a benchmark in which to compare change for the next audit anticipated in 2020.

Surveys were sent to 161 paediatric clinical directors in June 2017, garnering a 70% response. Each standard is presented with a headline result and accompanying graph with commentary distilled from the undertaking of site visits across the UK. Practice examples have been included to show where standards are being met well and involvement from the &Us Young Inspectors programme has enabled us to better understand how standard 8 from *Together for child health* has been met.

The fundamental principles underpinning the Facing the Future suite of standards is to ensure children are seen by the right professional, at the right time, in the right place. Future proofing children's services requires a sustainable workforce supported by sufficient numbers of trainees so that children's services are well equipped to deliver consultant led services.

The results of this audit continue to highlight that services are struggling to ensure a consultant paediatrician is available in the hospital during peak hours of activity, including at weekends. Whilst some improvements have been made since last auditing the acute general paediatric standards, a shortfall in the paediatric workforce needed to ensure that standards are being fully met across the UK continues to be a barrier. The audit findings demonstrate poor integration between primary care settings and the children's hospital service and a full summary of these results can be found on pages 12–14.

Data from the report has informed recommendations on pages 8–11 that the RCPCH will be working to implement over the next three years, until standards are audited again in 2020. We will be working with the Royal College of General Practitioners and Royal College of Nursing to support integration between general practice, community children's nursing teams and the paediatric hospital service to prevent unscheduled attendance or admission to the hospital.

The RCPCH maintain that standards should be used to inform discussions between service planners and clinical teams as a framework in which to plan and deliver high-quality services. We are here to support our members with implementing standards and look forward to discussing the results of the audit with members, key decision makers and children, young people and their families.

### **Dr David Shortland**

Chair, Facing the Future Audit Project Board  
Royal College of Paediatrics and Child Health

**Melissa Ashe**

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Royal College of Paediatrics and Child Health

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Project Officer

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## Recommendations

These recommendations are drawn from the results of the audit and also reflect the front-line evidence accumulated from visiting paediatric units across the UK. We welcome opportunities to work with stakeholders at local and national levels to implement and monitor the recommendations.

### **1. Governments must prioritise adequate resource to fund the workforce needed to fully implement standards in children's health services.**

There are not enough consultant paediatricians available to work during peak times in paediatric units across the UK. With substantial vacancies at consultant and trainee levels, attracting medical students into paediatric training and ensuring trainees progress to complete their Completion of Training certificate is vital. Workforce recommendations below are aligned with modelling underpinned by the RCPCH Medical Workforce Census 2015 published in 2017<sup>1</sup>.

#### **Recommendations for local and national stakeholders:**

- **Government should centrally fund an increase to the number of paediatric trainee places to ensure at least 465 WTE trainees enter each year of training in the UK for the next 5 years to achieve an expansion in the consultant-level workforce by 752 WTE across the UK.**
- **Health Education England must fund an increase in the number of paediatric trainee places to achieve an expansion in the paediatric consultant level workforce of 520-554 WTE.**
- **The Scottish Government must fund an increase in the number of paediatric trainee places to achieve an expansion in the paediatric consultant level workforce of 84-110 WTE.**
- **Health Education Improvement Wales must fund an increase in the number of paediatric trainee places to achieve an expansion in the paediatric consultant level workforce of 84-91 WTE.**
- **The Department for Health in Northern Ireland must fund an increase in the number of paediatric trainee places to achieve an expansion in the paediatric consultant level workforce of 30-31 WTE.**
- **Health Education England must clarify whether the expansion of medical undergraduate numbers beginning in 2018 and 2019 will translate into more**

**postgraduate training places in future years.**

- **Health Education England, the Scottish Government, Health Education Improvement Wales and the Department for Health in Northern Ireland must have an agreed strategy in place to increase the number of children's healthcare professionals with the appropriate competencies to work on paediatric training rotas by 2019\*.**

**RCPCH action:**

- **The RCPCH will continue to improve the promotion of paediatrics as an attractive specialty by removing the fee for Affiliate Membership for Foundation Doctors and improving the membership offer for both Foundation and Medical Students by 2019.**
- **Through the new RCPCH Recruitment and Retention strategy, the College will work to increase the recruitment fill rate into ST1 Paediatric Specialty Training to 95% by 2021.**

**2. Service planners and health organisations must work together to use standards to inform service design and planning.**

Audit results from *Facing the Future: Together for child health* standards provides vital evidence to show how poorly linked children's health services are across primary and secondary care settings. Placing paediatric expertise at the front end of the care pathway will help mitigate the rising attendance of children and young people to urgent and emergency care settings.

**Recommendations for local and national stakeholders:**

- **All children's Commissioners in England must ensure children's services are integrated across primary, secondary and tertiary care settings and professionals are working together to embed Facing the Future standards.**
- **The Scottish Government and NHS Scotland should identify the barriers to implementing guidelines and standards and then create an action plan to overcome them.**
- **NHS Wales and Public Health Wales should work together to support Health Boards to provide quality health and care services and support them to**

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\* Staff include Advanced Nurse Practitioners, GP Trainees and non-training medical doctors.

**implement guidelines and standards.**

- **The Department of Health, Health and Social Care Board and Health and Social Care Trusts in Northern Ireland should identify the barriers to implementing guidelines and standards then create an action plan to overcome them.**
- **The Department of Health in Northern Ireland should ensure that children's healthcare services are included in the Regulation and Quality Improvement Authority's inspection programmes for acute hospitals and community health services.**

**RCPCH action:**

- **The RCPCH will work with the Royal College of General Practitioners and Royal College of Nursing to improve pathways between primary and secondary care by hosting implementation events across the UK for paediatricians and child health professionals to support implementation of standards by 2021.**

### **3. Children's health services must be adequately funded and resourced.**

Evidence from audit site visits across the UK shows overwhelmingly that services are under financial pressure. Services for children and young people struggle for priority in strategic decision making and there is no evidence-based child health and wellbeing strategy for the UK, with little consideration of paediatrics in Health Education England's health and care workforce strategy.

**Recommendations for local and national stakeholders:**

- **The UK Government must commit to developing a cross-departmental child health improvement strategy for England by 2019.**
- **The Northern Ireland Executive must commit to developing a cross-departmental child health strategy by 2019.**
- **The Welsh Government must commit to publishing the Child Health Plan in 2019.**
- **The Scottish Government must demonstrate delivery of the Child and Adolescent Health and Wellbeing Action Plan using the accompanying framework by 2019.**

**RCPCH action:**

- **The RCPCH will work to support each Government with developing and implementing cross-departmental child health strategies with evidence of positive impact and results by 2021.**

#### **4. Health services must be tailored to meet the needs of children and their families.**

Children have a right to be involved in the design of their care. Children and their parents have told us that navigating health services is challenging. Ensuring that services and information systems share information across settings will enable children and their families better access to information and the resources needed to support self-management.

##### **Recommendations for local and national stakeholders:**

- **Health organisations must have a dedicated lead for children at executive or board level by 2020.**
- **By 2019, service planners must evidence the routine involvement of children and their parents/ carers into the design, delivery and evaluation of child health services.**
- **Local health systems must ensure healthcare professionals assessing or treating children in any settings have access to the child's electronic healthcare record by 2020.**

##### **RCPCH action:**

- **The RCPCH will support its Regional Leads and members to engage with service planners to ensure the voices and needs of children are represented at strategic decision making level.**

#### **5. Evidence gathering about new and emerging models of care, service design and delivery must be shared to drive improvements.**

The RCPCH works to collect and share examples of good practice and new models of care for members to support implementation of standards in daily clinical practice.

##### **RCPCH action:**

- **The RCPCH will continue to gather and identify examples of good practice and new models of care that will be shared with members through a series of RCPCH hosted Facing the Future implementation events and via the RCPCH website.**

# Audit results summary

## Standards for acute general paediatric services 2017

Standard 1	On weekdays, a paediatric consultant is present in the hospital during times of self-identified peak activity in 38.8% of units. At weekends, a paediatric consultant is present in the hospital during periods of self-identified peak activity in 28.6% of units.
Standard 2	79% of children admitted to a paediatric department with an acute medical problem were reported as being seen by a healthcare professional with the appropriate competencies to work on the tier two paediatric rota within four hours.
Standard 3	48% of children admitted to the paediatric department with an acute medical problem were reported as being seen by a consultant paediatrician within 14 hours of admission.
Standard 4	Twice-daily consultant led handovers are occurring in 51.6% of paediatric services.
Standard 5	100% of units report having rotas that allow children to have their case discussed with an appropriately competent child health professional before they are discharged. In practice, this happens 94.1% of the time.
Standard 6	For units with a paediatric assessment unit, 98.7% have access to a paediatric consultant in person or by telephone. 87.6% of units reported to have a paediatric assessment unit.
Standard 7	100% of units have a consultant of the week system in place.
Standard 8	Across all training rotas, 30.1% have 10 or more WTE.
Standard 9	Averaged across the eight specialties, 75.4% of units have access to specialist paediatricians for immediate telephone advice.
Standard 10	In 64.6% of units, all children, children's social care, police and health teams have access to a paediatrician with child protection experience (of at least level 3 safeguarding competencies) and skills to provide immediate advice and assessment for children where there are child protection concern 24 hours a day, seven days a week.

## Audit results summary

### Back to Facing the Future 2013

Standard 1	On weekdays, a paediatric consultant (or equivalent) is present in the hospital during times of self-identified peak activity in 25.6% of units. At weekends, a paediatric consultant (or equivalent) is present in the hospital during times of self-identified peak activity in 20.0% of units.
Standard 2	In the UK, 77.4% of children or young people admitted to a paediatric department with an acute medical problem are seen by a paediatrician on the middle grade or consultant rota within four hours of admission.
Standard 3	In the UK, 87.7% of children or young people admitted to a paediatric department with an acute medical problem are seen by a consultant paediatrician (or equivalent) within the first 24 hours.
Standard 4	94.1% of units have at least one medical handover in every 24 hours led by a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
Standard 5	99.2% of UK units have a rota structure which allows every child or young person with an acute medical problem who is referred for a paediatric opinion to be seen by, or have their 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. In practice, this happens in 95.8% of units.
Standard 6	Of units with SSPAUs, 98.9% have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open, either in person or by telephone.
Standard 7	92.4% of units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
Standard 8	Across all rota tiers, 28% have 10 or more whole time equivalent (WTE).
Standard 9	Averaged across the eight subspecialties considered, 85.3% of units have access to specialist paediatricians for immediate telephone advice.
Standard 10	In 82.5% of units, 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 24 hours a day, seven days a week.

## Audit results summary

### *Together for child health*

Standard 1	GPs have access to immediate telephone advice from a consultant paediatrician in 86.2% of units.
Standard 2	26.4% of acute general children's services provide a consultant paediatrician-led rapid-access service so that any child referred can be seen within 24 hours.
Standard 3	7.4% of paediatric units reported having a link consultant paediatrician for each GP practice or group of practices.
Standard 4	48.9% of acute general children's services provide biannual education knowledge exchange sessions with GPs and other healthcare professionals.
Standard 5	14.9% of acute general children's services are supported by a community children's nursing service that operates 24 hours a day, seven days a week.
Standard 6	11.2% of GP practices are linked with a community children's nurse.
Standard 7	75.8% of children's acute services send the discharge summary electronically to the child's GP and relevant health professionals within 24 hours with information given to the child and their parents and carers.
Standard 8	84.0% of units provide verbal and written safety netting information to children and their parents upon discharge.
Standard 9	45.1% of paediatric services report that healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic health record.
Standard 10	16.9% of acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.
Standard 11	27.2% of units have documented, regular meetings with hospital, community and primary care services, with representation of children and families to monitor, review and improve the effectiveness of local unscheduled care services.

## Introduction

The *Facing the Future Audit 2017* lays out evidence to demonstrate how paediatric services across the UK are meeting standards within *Facing the Future: Standards for acute general paediatric services* and *Facing the Future: Together for child health*.

The purpose of the audit is three-fold. Firstly, to monitor whether services are meeting standards that enables us to build a picture of paediatric provision across the four nations. Secondly, to assess whether the standards are impacting upon services in the front line; if they are driving improvement, supporting clinical leads or ensuring services are operating sustainably. And lastly, but most importantly, to ascertain what bearing the standards have on the quality of care that is being provided to children, young people and their families.

Using self-reported survey data, front-line evidence from the undertaking of site visits and with feedback from the &Us Young Inspectors programme, we have provided a picture of the current state of general paediatric services across the UK. We present the results using headline data, graphical presentation, practice examples that show how standards are being met well including examples of how children and young people want to be cared for when they present to hospital.

Since last auditing the acute general paediatric standards in 2013, radical reorganisation of services and new models of care and purchasing arrangements have taken place in England. Since the update and release of both sets of standards in 2015, political uncertainty has increased across the UK.

The RCPCH is committed to supporting members at local, service and national levels to ensure high-quality paediatric care is equitable and sustainable across the UK. Standards for acute general paediatric services have been used to inform NHS England's Seven Day Hospital Services audit and have been aligned with three out of their four clinical priority areas<sup>2</sup>.

We have seen evidence that service planners are using Facing the Future standards to inform the design and delivery of the best quality standard of care. However, austerity and a lack of attention by policy makers to the issues faced by children's services and insufficient workforce resource means that services are struggling to deliver standards.

*"Local paediatric Productive Elective Care (PEC) meetings are currently our vehicle for engagement with local CCGs and community paediatric services to develop care pathways integrated between acute and community for children. Instigated approximately 18 months ago, we are starting to produce output which will influence Facing the Future standards and are planning to use that forum to further address the standards locally."*

**Hull and East Yorkshire Hospitals NHS Trust**

## Background

*Facing the Future: Standards for acute general paediatric services* were first introduced in 2010 and were designed to underpin a consultant delivered service fit for the 21<sup>st</sup> century. These were closely followed in 2011 by *Facing the Future: A review of paediatric standards*, which reiterated the standards and provided workforce and service provision modelling around their implications. The standards covered issues such as the number of doctors required on rotas, the availability of consultant advice in different settings and the responsibilities of paediatricians in respect of child protection services. Analysis was undertaken to understand what implications the standards would have on the paediatric workforce and the work concluded that major reconfiguration was necessary in order for standards to be implemented; namely a reduction in paediatric inpatient units and fewer trainees, and an expansion of the consultant workforce.

These standards were audited in 2012 and the final report in 2013 highlighted that whilst *Facing the Future* standards had been embraced by paediatricians in their daily clinical practice, standards were not being met as regularly at weekends and evening as they were between 9am and 5pm. Results from the audit and from coroners' reports that recommended for a more timely senior clinical review of sick children informed an update and revision to standards in 2015 that coincided with the release of standards for unscheduled care.

*Facing the Future: Together for child health* expanded the *Facing the Future* suite of work in 2015 into care outside of the hospital, aiming to ensure high-quality care is provided from first contact and to reduce unnecessary attendances at emergency departments and admissions to hospital. Standards were developed in partnership with the Royal College of General Practitioners and Royal College of Nursing and operate to build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

Further workforce modelling illustrated in the RCPCH *State of Child Health* workforce report lays out that at least 752 WTE extra consultants are required to meet the *Facing the Future* standards and specialist services standards<sup>3-8</sup>. Furthermore, an increase in the number of trainees entering paediatrics to 465 in each training year for the next five years is required to meet *Facing the Future* standards for consultant numbers (this is a 15% increase from 2016).

## RCPCH &Us involvement

RCPCH &Us involves children, young people and parent/carers across the UK through consultations, challenge days and projects, giving them the opportunity to improve health policy and practice.

Within the *Facing the Future* programme, children, young people and parent/carers have contributed to the development of *Facing the Future* standards for ongoing health needs, developed information and resources as part of the *Facing the Future Superhero* project and have worked as Young Inspectors to support auditing the *Together for child health* standards.

In the summer of 2017, five young people and one parent carer underwent training, as part of the RCPCH &Us Young Inspectors Programme.

The purpose of this project was to train and support young people and parents/carers to examine and assess how local services can identify where they could be better and help them improve the service.

Since the training, young people/parent carers have been informing and influencing the Facing the Future Audits, specifically looking at standard 8 in *Facing the Future: Together for child health* on “discharge”, taking part in site visits where school and college commitments permitted.

These visits have shown the need for local areas to work in partnership with children and young people, and their parents and carers to understand their needs so that outcomes can be improved. Key areas for services to focus on include:

- Communication formats with children and young people around discharge
- Having children and young people friendly and appropriate settings
- Knowing local engagement providers and support services to signpost children and young people

For more information about the Children and Young People’s Engagement Team at the RCPCH and how we include children and young people’s voice in the work of the College, get in touch via [and\\_us@rcpch.ac.uk](mailto:and_us@rcpch.ac.uk).



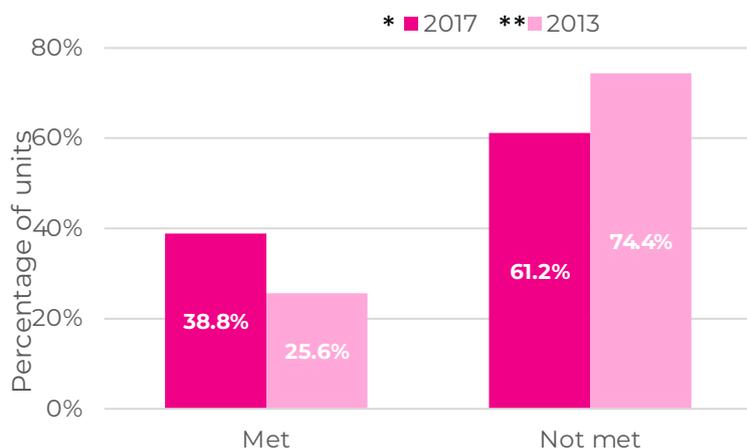
# Standard 1

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

## Headline results

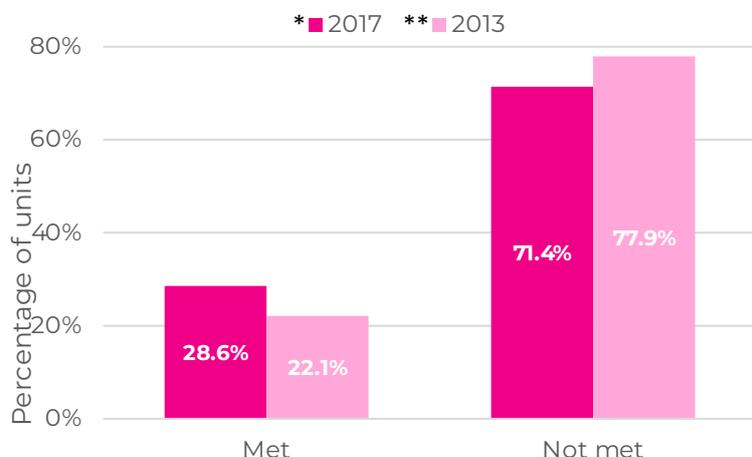
On weekdays, a paediatric consultant is present in the hospital during times of self-identified peak activity in 38.8% of units. At weekends, a paediatric consultant is present in the hospital during periods of self-identified peak activity in 28.6% of units. 103 units provided data for weekdays compared with 56 units providing data for weekends. Data for consultant presence during weekends therefore presents a partial picture.

**Figure 1: Consultant presence during self-identified peak periods on weekdays (comparison with 2013)**



\*2017 n=103; data missing or unknown for 10 units  
 \*\* 2013 n = 106; data missing or unknown for 15 units

**Figure 2: Consultant presence during self-identified peak periods on weekends**



\* 2017 n = 56; data missing or unknown for 50 units.  
 \*\* 2013 n = 104; data missing or unknown for 17 units

Both the RCPCH and Academy of Medical Royal Colleges have outlined the benefits of consultant delivered care, which affords rapid and appropriate decision-making, efficient use of resources, continuity of care, and an improved work life balance for clinicians<sup>9,10</sup>.

The audit has revealed data to suggest that most units are unable to provide a consultant presence to cover peak times. We know through RCPCH reporting in the biannual Workforce Medical Census and the annual Rota Compliance and Vacancies Survey that paediatric services struggle to sufficiently fill their rotas<sup>11,12</sup>. Services have told us that financial constraints and workforce issues are preventing compliance with this standard, most notably in England. Some units expressed concern over the difficulty in retaining the current workforce population, many sharing their view that consultants are leaving the profession due to increased work-load pressures and demand.

Site visits showed us that consultants frequently go beyond the call of duty to ensure peak times are appropriately staffed. Some clinical leads expressed concern that high level consultant presence can potentially limit the development of trainees. When rotas are well-staffed trainees have opportunities to develop independent clinical decision making with consultant supervision.

Such services should ensure that consultant presence is provided during times of peak activity and this should be accurately represented in the work plans of consultant paediatricians. With provision of adequate resources, informal arrangements of consultant availability via telephone should be replaced by physical consultant presence. The RCPCH recommends that standard one is implemented alongside standard seven of the acute general paediatrics standards, as 'consultant of the week' systems can be utilised to provide cover during times of peak activity.

The RCPCH recommends that these standards are used to develop relationships with service planners and commissioners, as they provide a framework in which to develop service-level agreements. Evidence from the RCPCH Workforce Medical Census together with Facing the Future standards are tools to support clinical leads to influence for well-resourced services<sup>1,3,13</sup>.

For services requiring support with workforce modelling or that require an invited review to understand how to make improvements, support is available by contacting the RCPCH workforce team and invited reviews service at [workforce@rcpch.ac.uk](mailto:workforce@rcpch.ac.uk) and [invited.reviews@rcpch.ac.uk](mailto:invited.reviews@rcpch.ac.uk).

**Practice Example**

**Barnsley Hospital NHS Foundation Trust**

The paediatric unit at Barnsley Hospital NHS Foundation Trust is staffed by eight acute care consultants and one community consultant who take part in on-call duties. There is usually a peak in activity during late afternoon and into the evening.

The unit operates a consultant of the week or 'hot week' system that operates 9am to 5pm, Monday to Friday to include consultant led handovers with junior doctors at 9am and 4.30pm. During Monday to Friday, a different consultant is on site each day of the week to cover on-call until 10pm and this includes leading the third handover of the day at 9pm that evening.

On weekends, one consultant is on site from 9am until 2.30pm to include handover with trainees at 9am. The consultant leaves the site where possible, but remains on-call from 2.30pm and returns to the hospital at 7.30pm to review all new admissions and lead the evening handover before leaving at 10pm. The same consultant would then remain on-call for the night.

Barnsley Hospital has had positive experiences in recruiting consultant paediatricians. As it stands, there is sufficient consultant cover to ensure on-call is managed well, though recruiting two more consultants would help to ensure better on-call workflow and better support with day-time activities.

Further details: Dr Sunil Bhimsaria, Consultant Paediatrician and Clinical Lead [sunilbhimsaria@nhs.net](mailto:sunilbhimsaria@nhs.net) Barnsley Hospital NHS Foundation Trust.

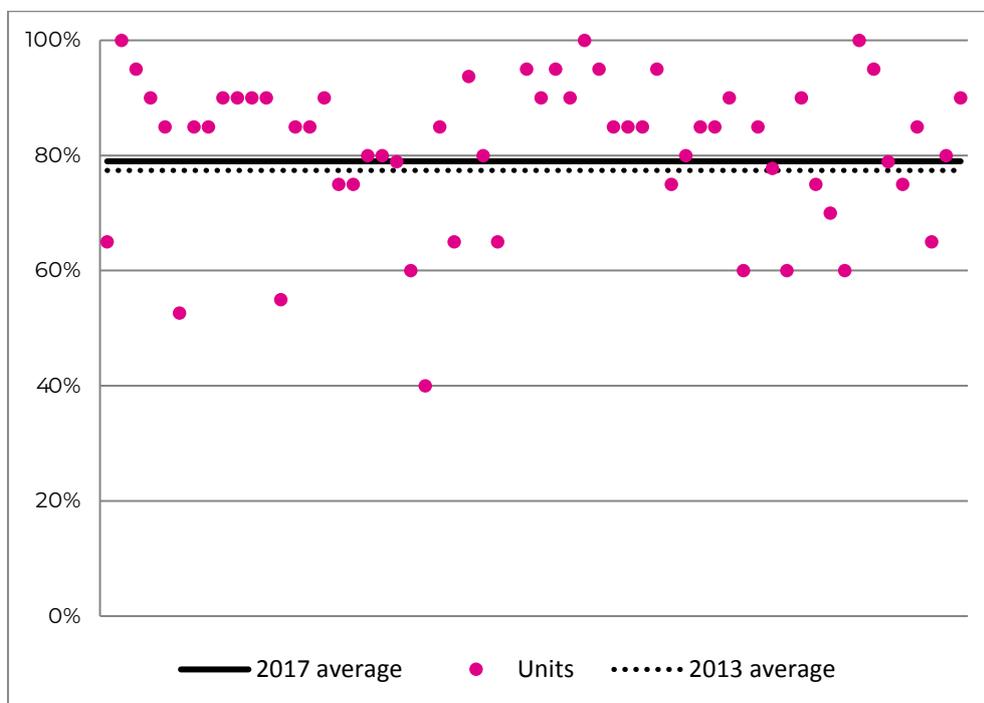
## Standard 2

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.

### Headline results

On average 79% of children admitted to a paediatric department with an acute medical problem were reported to be seen by a healthcare professional with the appropriate competencies to work on the tier two paediatric rota within four hours.

**Figure 3: percentage of children seen by a tier two doctor or consultant within 4 hours (comparison with 2013)**



Introduced in 2004, the NHS four-hour access standard provided the mandate for at least 95% of patients attending the emergency department to be admitted, transferred or discharged within four hours<sup>14</sup>. The audit results demonstrate how this target has been embedded within acute paediatric care and services have demonstrated a willingness to reach this standard well.

It was noticeable during site visits that units struggling to recruit into tier two rotas were more likely to struggle to meet this standard. For some units, consultants were having to 'work down' in an unplanned way to registrar level to ensure the standard could be met.

The impact of poor data quality is likely to impact upon the variation in results presented here. We recommend that quality improvement activities are sought out to ensure accuracy in data collection and that these activities are continually audited.

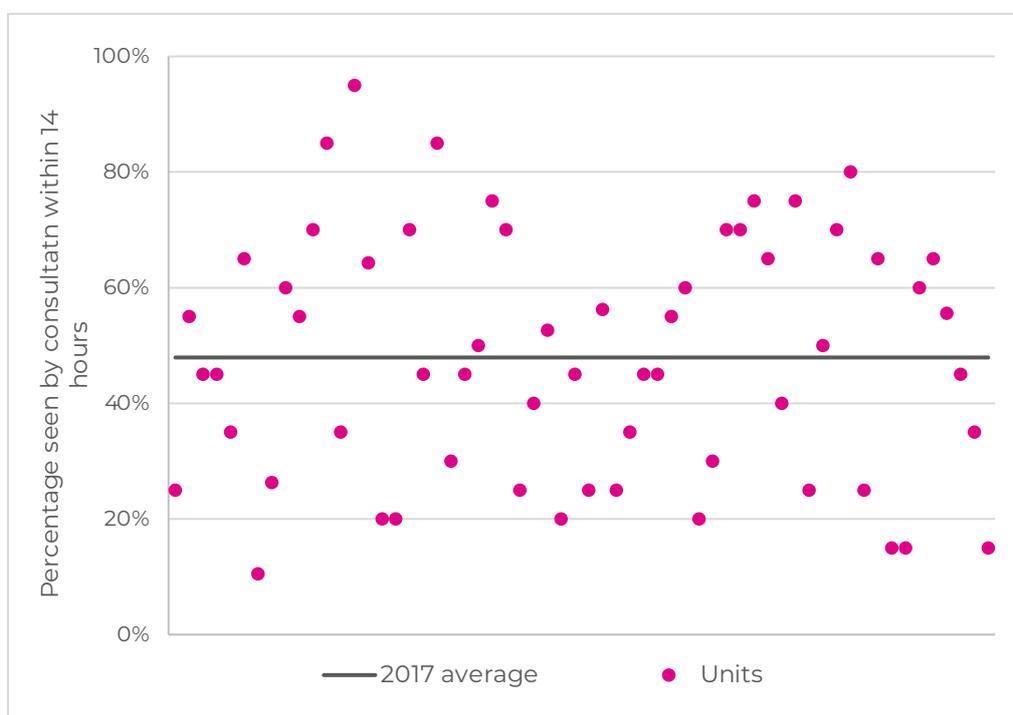
## Standard 3

**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 of staff is concerned.**

### Headline results

48% of children admitted to the paediatric department with an acute medical problem were reported as being seen by a consultant paediatrician within 14 hours of admission.

**Figure 4: percentage of children that have been seen by a consultant within 14 hours of admission.**



Data note: 161 units were asked to complete a retrospective audit of 20 case notes between 01/03/2017 and 31/05/2017. 60 units returned the case note audit and six units had incomplete data ranging from one to six missing cases.

The assessment of an acutely sick child is challenging and requires healthcare professionals to have the appropriate skills and competence<sup>15</sup>. No units were able to meet this standard for 100% of children.

Previous Facing the Future standards recommended that children should be reviewed by a consultant paediatrician within 24 hours of admission<sup>3</sup>. This timescale was revised to 14 hours in 2015 based upon themes emerging from coroners reports on a number of child deaths concluding that children required a more senior and timely opinion, and by consensus of expert opinion and wide-ranging consultation with key stakeholders including children and their parents/ carers. This standard is aligned with the Royal College

of Physicians acute care toolkit that recommends that any newly admitted patient must be seen by a consultant within 14 hours of arrival on any acute medical unit and units in England are mandated to meet this standard through the NHS England Seven Day Hospital Services clinical priorities<sup>2,16</sup>.

Analysis of the case notes has enabled us to see that children admitted onto wards in the late evening are less likely to be seen by a consultant within 14 hours as they would often have to wait until the morning ward round to be seen. For example, where units hold morning ward rounds at 9am, children being admitted between 5pm and 7pm the previous evening would not meet the standard. The practice example from Barnsley Hospital illustrating standard one in this document, demonstrates how the consultant review within 14 hours of arrival can be met.

Feedback from the site visits highlighted issues relating to the need for patients to be physically seen by consultants within 14 hours, especially during the overnight period. Many units reported undertaking a 'verbal handover' at approximately 10 or 11 o'clock at night, to keep the consultant informed of the number of patients and their acuity. It was felt that more resources were required to meet these standards, as current staffing levels could not sustainably meet the 14-hour timescale. Clinical leads reported that increased level of activity on the ward and limited bed availability could result in discharge of stable children prior to consultant review.

Some clinical leads suggested that the necessity for consultant review in 14 hours can stifle the progression of junior doctors for common conditions, such as tonsillitis. The RCPCH maintains that trainees should be supported to lead on clinical decision making whilst supervised.

Where data are not accurately recorded within case notes, it cannot be made clear whether compliance with standards is due to poor data quality or due to staff shortfalls including consultant presence. It is recommended that units regularly audit these timings to encourage habitual recording of data in an accurate way and where timings need to be improved, plans to implement change is communicated to all staff members. The audit team were pleased to see this already embedded in several units.

**Practice example**

RCPCH produced a Workforce Implications discussion document to accompany the revised version of Facing the Future standards in 2015.

The following analysis shows the weekly number of general acute programmed activities (PAs) required to meet the revised standards for a range of different types of units. Individual units may need to adapt these models to suit their individual configuration.

Size of unit	Daily consultant presence (hours)	Acute paediatric outpatient clinics per week	Acute PAs per week required
Very small	8 -12	10	48.1 – 56.1
Small	8 -12	15	54.4 -62.3
Medium	12	20	68.6
Large	12	25	74.8
(Very) Large	12 (2 consultants)	25	118.4

Meeting these workforce measures should provide compliance with standards 1, 2, 3 and 4.

The full Workforce Implications document can be found at [www.rcpch.ac.uk/facingthefuture](http://www.rcpch.ac.uk/facingthefuture)

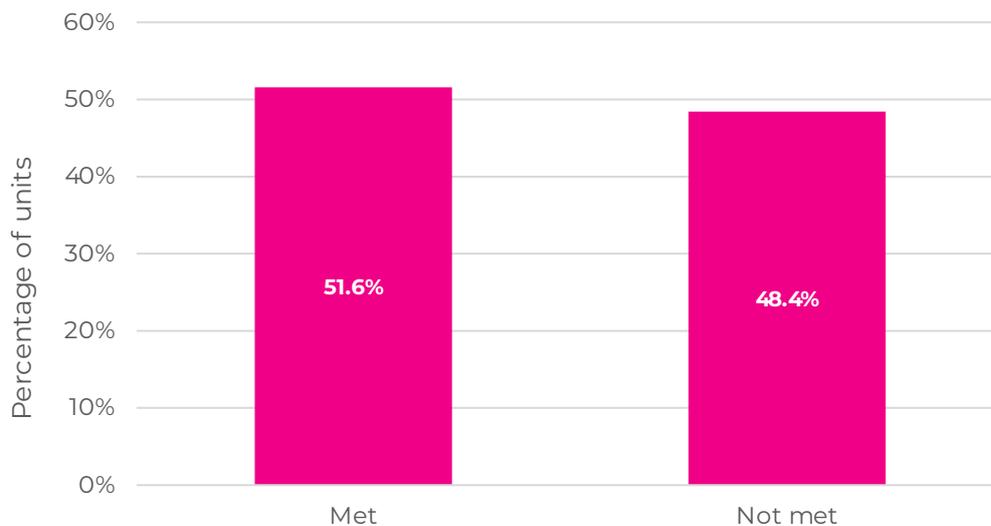
## Standard 4

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

### Headline results

Twice-daily consultant led handovers are occurring in 51.6% of paediatric services.

**Figure 5: percentage of units that have at least two or more consultant led handovers every 24 hours**



n = 93; data missing or unknown for 18 units

The 2013 audit of acute standards showed 94% of units implementing at least one medical handover in every 24 hours led by a paediatric consultant. These data were used to inform an update to the standard to state that at least two medical handovers should take place every 24 hours and should include a system risk assessment for each patient that identifies issues around early warning scores or systems, complex cases, an awareness of incoming referrals and potential unanticipated staffing level issues.

Clinical leads and trainees alike report that they want to reach and ultimately meet this standard. Sharing information using structured communication techniques not only helps to keep all medical and nursing staff aware of each patient being cared for, it helps to provide oversight of a service area as well as identifying any unanticipated issues.

Whilst the standard itself states that trainees should be encouraged to lead handovers whilst supervised by a consultant for development opportunities, we have seen during site visits that this is not happening to the degree that trainees would like. Our data shows that twice daily handovers are more likely to incur during weekdays than at weekends, with

some units reporting that during peak hours, or when the emergency department is especially busy, it is a struggle to get an evening handover to happen.

We know that handovers look different in every unit across the UK and we have seen examples of excellence, both in format and in the increased confidence of staff caring for the children discussed. What we are seeing more frequently, is the involvement of other staff groups (notably lead nurses and pharmacists) within handover so that information is shared widely across the children's healthcare team.

### **Practice Example**

#### **Bedford Hospital NHS Trust**

Handover occurs three times a day at Bedford Hospital to cover patients from the general paediatric unit and neonatal and transition care beds, which amounts to anything up to 40 patients at peak times. Handover lasts an average of 30 minutes and are structured using the RCPCH Handover Assessment Tool that supports assessments being formative, puts patient safety at the centre of the handover, provides clear and structured communication whilst ensuring the sickest patients and issues are prioritised.

Handover during the week happens at 9am, 4.30pm and 9pm. The morning handover includes the consultant of the week, the neonatal consultant, the nurse in charge, registrars and trainee doctors. The 4.30pm handover includes the evening/overnight consultant who will be on site until 9.30pm after leading the 9pm handover. During the weekends, handover occurs at 9am and 9pm.

Trainees are encouraged to lead on handovers to support training opportunities that are overseen and supported by the consultant. In auditing the handovers, trainees and consultants alike can improve their handover technique, receive feedback and learn from the points identified. As a result of the handover frequency and format, consultants feel better informed of the care that is being delivered to children in the general paediatric and neonatal wards.

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RCPCH Handover Assessment Tools are available via

<https://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/assessment/hat-handover-a>

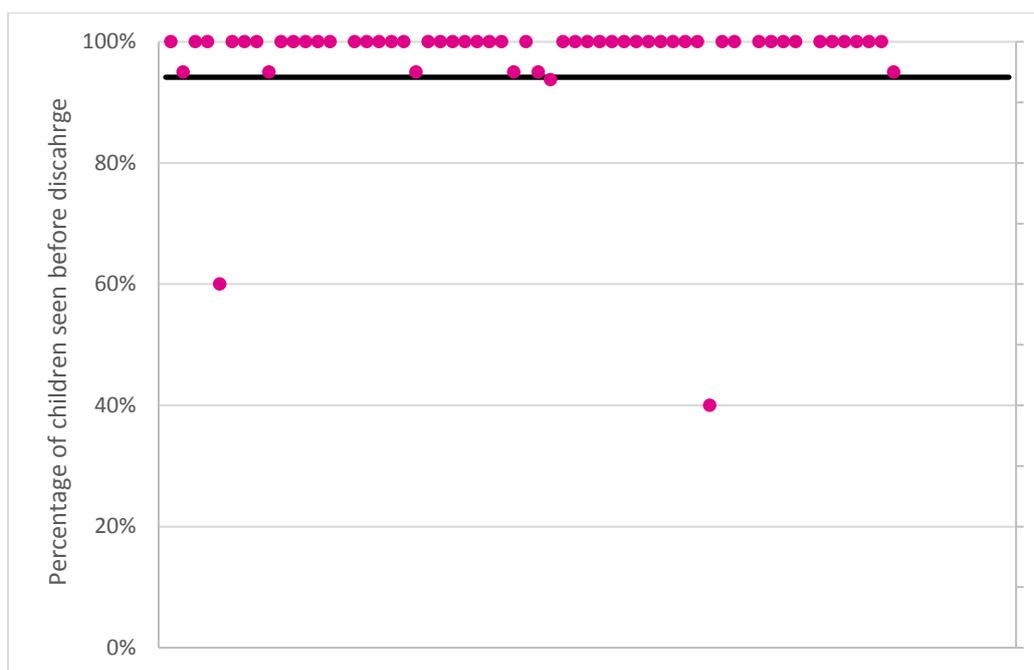
## Standard 5

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.

### Headline results

100% of units report having rotas that allow children to have their case discussed with an appropriately competent child health professional before they are discharged. In practice, this happens 94.1% of the time.

**Figure 6: percentage of children seen by or had their case discussed with a clinician with the necessary skills and competencies before discharge**



Data note: 161 units were asked to complete a retrospective audit of 20 case notes between 01/ 03/ 2017 and 31/ 05/ 2017. 60 units returned the case note audit and six units had incomplete data ranging from one to six missing cases. One unit had all 20 values missing for Standard 5.

All children should be seen by healthcare professionals with appropriate expertise to provide a high level of care for each patient. Senior doctors (usually at ST4 and above) are capable of discharging patients. As of August 2018, the new RCPCH curriculum states that any trainee will be able to discharge patients based upon the discretion of their

supervisor<sup>17</sup>. The Royal College of Nursing (RCN) have defined the role of an advanced nurse practitioner to include, "...having the authority to admit or discharge patients from their caseload"<sup>18</sup>.

RCPCH supports a multi-professional approach to discharge, which promotes a supportive and collaborative environment within units. Standard 5 aims to provide an educational experience and opportunity for progression of junior doctors and advanced nurse practitioners alike. Benefits of sharing the discharge workload include patients being discharged quicker, better bed management, increased patient flow through wards, and freeing up consultants' time for more urgent matters.

Site visits have shown us that systems are in place to ensure junior trainees seek the medical advice from a middle grade or more senior paediatric colleague before sending children home. Whilst some sites report that this standard can hinder trainees from taking responsibility for their clinical decision making, we have seen examples to show how consultants can work together with level one trainees (ST1-3) to develop clear criteria plans to enable trainees to discharge patients without more senior review. It should be noted that criteria led discharge is carried out for children with 'straightforward' diagnoses, such as asthma, whilst children presenting with acute and complex medical problems require senior review before discharge.

The RCPCH Medical Workforce Census 2015 reported that 60% of units in the UK employ advanced nurse practitioners (ANPs), with an estimated total of 426 whole time equivalent (WTE) ANPs working in paediatrics, however there has been little increase in the proportion working on paediatric medical rotas than reported in the previous census<sup>1</sup>. There was a range of views on the benefits and role of ANPs in acute paediatrics and this area will require more attention.

RCPCH standards and guidance recommends that advanced children's nurse practitioners are competent to lead care in paediatric assessment units with co-located consultant support<sup>19</sup>. Visits showed us that in some areas the role of ANPs is not clearly defined, which has resulted in some confusion around the ability for ANPs to provide clinical decision making. RCN guidance clearly outlines the role

*"It's a much better phrased standard, because it is talking about people's competency and experience. It is saying that it doesn't matter who that person is, but it is someone with the 'appropriate competency'. If a parent was reading it, they would then recognise that other people can have that competency to do it. A lot of people would be quite happy or even delighted to see our CNS or ENPs nurses because actually they know a lot."*

**Clinician, Homerton University Hospital**

and competencies which can be expected of advanced nurse practitioners and should be consulted by units seeking to develop nursing roles<sup>18</sup>.

The training and funding of ANPs to fill tier 2 rotas was offered as a viable solution for many paediatric services struggling to provide sufficient workforce, but sites report that recruiting ANPs into service has been difficult due to an overall shortage of registered children's nurses<sup>20</sup>.

Consultants should work together with junior trainees and ANPs to develop clear criteria plans for discharge, to support their development and increase their decision-making capacities. Where criteria led discharge plans are in place, there should be instructions on escalation policies. NHS Improvement in England has developed a guide to implement criteria led discharge, to be used in conjunction with existing care pathways to tackle delays in discharge and improve patient satisfaction<sup>21</sup>.

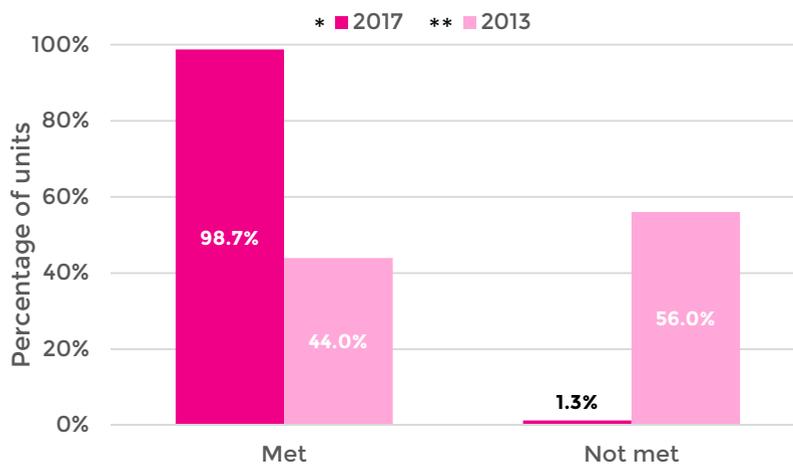
## Standard 6

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

### Headline results

For units with a paediatric assessment unit, 98.7% have access to a paediatric consultant in person or by telephone.

**Figure 7: percentage of Paediatric Assessment Units that have access to a consultant paediatrician in person or by telephone (comparison with 2013)**



\* 2017 n = 79; data missing or unknown for 6 units.

\*\* 2013 n = 91; number with data missing is unknown

Paediatric assessment units (PAUs) have emerged as an effective and integral model of care for children that can help to reduce the number of inpatient admissions, support a higher turnover of patients and reduce overall length of stay due to earlier discharge. *RCPCH Standards for Short-Stay Paediatric Assessment Units (SSPAU)* are now available to support existing and establishing units<sup>19</sup>. There are now 178 paediatric assessment units in the UK with a noticeable appetite from health organisations to set up new units<sup>1</sup>. Co-locating PAUs with children's wards or emergency departments allowed for flexibility in staffing, which as a result enables units to better manage peak attendance.

Some units reported that nursing availability seemed to have a significant leaning on whether the PAU is open or closed, with other commenting that medical staffing availability has most impact on its opening hours.

For more rural units and for smaller DGHs, units are often struggling to staff PAUs with nurses, an issue that can be exacerbated during busy periods in the paediatric emergency department. Overall this model of care is working well and clinical leads are in favour of

middle grade doctors working in PAUs with access to a consultant opinion by telephone, by way of encouraging autonomy in trainees.

### **Practice Example**

#### **Basildon and Thurrock Hospitals NHS Foundation Trust**

Basildon hospital has a four bed paediatric assessment unit with one treatment room and is open 24 hours a day, seven days a week. It has been co-located with the paediatric emergency department since 2014, having previously been located within the paediatric ward.

There are two consultants available during peak periods between 9am and 10pm, seven days a week as well as two registrars. On weekdays, the consultant of the week covers the paediatric assessment unit (PAU) between 9am to 5pm and an evening consultant is available between 5pm to 10pm with two registrars; one doing a 3pm to 11pm shift and another starting at 5pm finishing at midnight, thus allowing crossover during the busiest point of peak times. On weekends consultants are available on site between 9am to 5pm.

For the night shifts, there are two registrars at the PAU. Consultants are on call from 10pm on weekdays and 5pm weekends and they can be contacted via telephone for immediate advice, or in person within 20 minutes if required.

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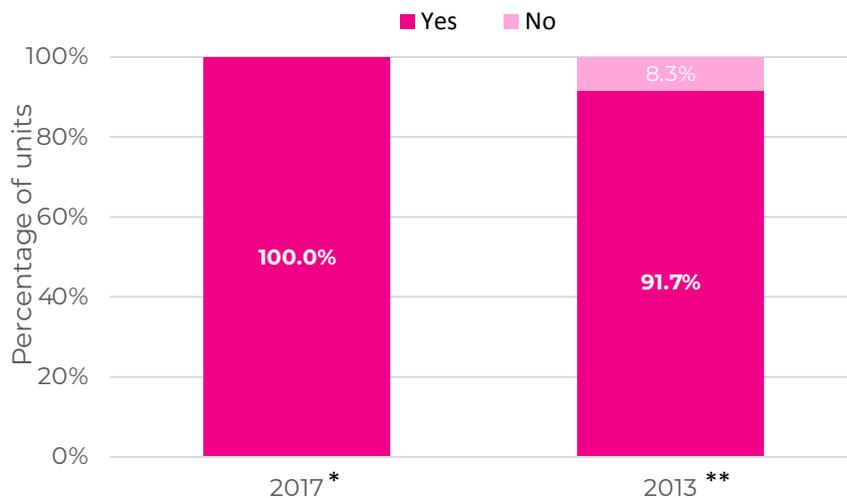
## Standard 7

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

### Headline results

100% of units have a consultant of the week system in place.

**Figure 8: percentage of units that have a consultant of the week system (comparison with 2013)**



\* 2017 n = 96; data missing or unknown for 17 units

\*\* 2013 n = 120; data missing or unknown for 1 unit

The RCPCH Workforce Census 2009 found consultant of the week systems to be almost universal, with only 2.3% of inpatient services and 2.5% of neonatal services not operating in this way<sup>22</sup>. Just short of a decade later, results from the 2013 audit showed 91.7% of units had established a system, which has pleasingly increased to 100% of units from this audit.

Clinical leads reported that the standard provides continuity of care for patients and that this helps to improve patient satisfaction, including the benefits of patients knowing and recognising their doctor. Having a consultant of the week improves visibility and presence on the ward and their availability for urgent advice, which also improves satisfaction from junior doctors and nurses to access greater levels of support. One of the underpinning principles of Facing the Future advocates for 'consultant delivered care', whereby the consultant takes clinical responsibility for hands-on and close supervision of the care of patients<sup>9</sup>. Some units have adopted a peer review process that is embedded into the consultant of the week system with other professionals contributing to discussions during daily medical handovers.

Site visits has shown us that implementation of the consultant of the week system has been variable. Some consultants have interpreted standard 7 to mean consultant ward

rounds over the week, whilst others have hosted a GP hotline for the week. Clinical leads have reported time constraints on staff as a barrier for implementation. An understaffed workforce can be exacerbated by the mix of job plans needed to staff rotas; including consultants who work part-time, those who 'don't do' consultant of the week or staff who may be on long term leave. Consultants are likely to face pressures to complete other clinical duties or external commitments, such as attending clinics or child protection duties. Consequently, this feedback raises concern over the sustainability of standard 7. Survey results revealed the risk of staff burnout from being overworked, as consultant of the week systems can often be demanding on the individual.

Many units demonstrated reasonable solutions to increased workloads created by consultant of the week systems. Notably, it is encouraged to split the week into manageable blocks, so that no consultant is working for a continuous seven-day period. Some units reported splitting the week into a five-day week and two-day weekend with some being available via on-call only during the weekends. Other units adopted a strategy of sharing the consultant of the week in a 'buddy' system by either having two consultants or having a deputy consultant. One hospital recommended relieving consultants of their other duties from 9am to 6pm during the week, to enable their focus on the consultant of the week role.

NHS Improvement has recommended that job plans are reviewed on a regular basis, to ensure that working patterns reflect the changing demand of service delivery<sup>23</sup>. Feedback should be sought from staff and patients on a regular basis to review the effectiveness of the current consultant of the week system. RCPCH recommends that team job planning is helpful to determine how best to meet the needs of the service and individuals<sup>9</sup>.

### **Practice Example**

Sites across the UK are meeting this standard well. Please contact the health policy team for guidance if you require support [health.policy@rcpch.ac.uk](mailto:health.policy@rcpch.ac.uk)

## Standard 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.

### Headline results

Across all training rota tiers, 30.1% have 10 or more whole time equivalent posts.

**Table 1: Average WTE by rota type and tier**

	Tier 1 general - WTE	Tier 1 general / neonatal - WTE	Tier 2 general - WTE	Tier 2 general / neonatal - WTE	Tier 3 general - WTE	Tier 3 general / neonatal - WTE
Average	9.7	10.2	9.8	9.0	10.1	8.9
n	40	55	29	61	25	50

The 2016/ 2017 Paediatric Rota Gaps and Vacancies Survey reported a vacancy rate of 14.6% on tier 1 rotas and 23.4% on tier 2 rotas with the average general paediatric training rota size in UK units falling below 10 WTE as stated within this standard<sup>12</sup>. The results here further illustrate the challenges units have in filling rotas and site visits across the UK tell us that a multifaceted approach to filling rotas is required to tackle deficiencies in tier 2 rotas. The tier 1 and tier 2 rotas are mainly staffed by doctors in the paediatric training programme, with a small growth in other groups of staff to provide these services<sup>1</sup>.

Trainees have told us that the loss of pay premiums for paediatrics under the new junior doctor contract in England is potentially damaging for the reputation of paediatrics. Paediatrics comes fourth in the list of shortages in specialties, following general practice, emergency medicine and psychiatry, but where those three specialties are recognised under the new contract and attract a financial pay premium, paediatrics does not. The RCPCH State of Child Health workforce report has recommended that paediatrics should immediately be placed on the shortage occupation list, with exemption from the resident labour market test<sup>8</sup>.

*"I love working in paediatrics. I feel passionate and motivated to be part of an amazing team who want the best for children. The whole multi-disciplinary team work daily to look after children, support, train and educate each other. Furthermore, I have been supported in my training to explore and develop additional interests in simulation, integrated care, education and work abroad. This is the job for me, I wouldn't want to do anything else"*

**Trainee Representative on Facing the Future Audit Project Board (North-East Central)**

Discrepancies in reporting on trainee places, for example between Health Education England, the General Medical Council and the RCPCH, is known and continues to cause issues in the timely recruitment of middle grade doctors. Units reported that the provision of trainees can depend on their relationship with the Deaneries or Local Education and Training Boards and some units which are short of staff and struggling to meet patient demand are less attractive to them, as they are not afforded the time to properly train their doctors and therefore are less likely to be awarded more trainees.

Trainees told us that paediatrics is more likely to attract a workforce who are in less than full time training, meaning progress to gain Completion of Training certification takes longer, which could be negatively impacting the provision of a full workforce.

### **Practice Example**

#### **RCPCH Trainee Survey**

The RCPCH Trainee Committee Survey (2017) investigated the general mood of 1,019 paediatric trainees<sup>24</sup>. Results concurred with the evidence presented within this audit, specifically in highlighting the lack of a sufficient paediatric trainee workforce. Only 59% of trainees felt that their current staffing levels provided a safe working environment. Shortages in rotas has had consequential negative impacts upon the working patterns of trainees – 46% of trainees felt that they did not have enough rest between their shifts and 45% were unable to take annual leave when they wanted to. With an increased and intensified demand placed upon trainees, many survey respondents questioned the sustainability of the current paediatric trainee model, as only 43% were hopeful about the future of paediatric training.

Despite the challenges faced by trainees, they retain enthusiasm about their paediatric careers. Importantly results portrayed high levels of morale, 79% of trainees expressed motivation to work in paediatrics and 90% intended to complete their training. A further 66% felt that they were fairly paid for the work that they do. Arguably, when paediatric trainees are appropriately supported in their role their satisfaction levels are higher. Results showed that 75% of trainees had acceptable access to study leave, ensuring they were able to continue in their professional development.

These results signify the passion and determination of the current paediatric training cohort. Though they are under increasing pressure from trainee rota gaps, they continue to enjoy and value paediatrics as a career. Anecdotally, trainees and consultants alike have suggested that the being a paediatrician brings benefits in making a meaningful difference to the lives of children.

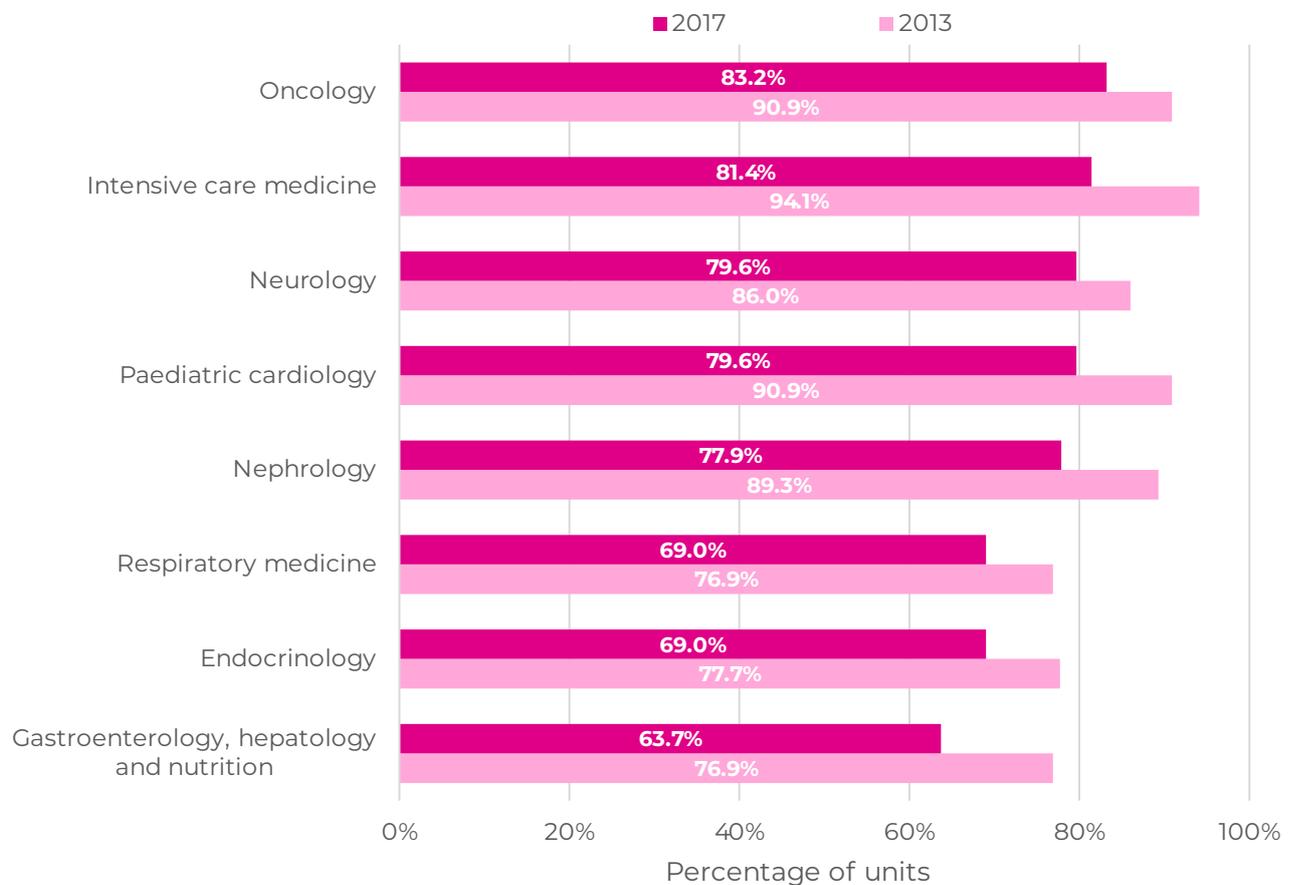
## Standard 9

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

### Headline results

Averaged across the eight specialties, 75.4% of units have access to specialist paediatricians for immediate telephone advice.

**Figure 9: Percentage of units where specialist paediatricians are available for immediate telephone advice (comparison with 2013)**



Access to specialist paediatric advice is crucial to enable general paediatricians to appropriately and effectively manage the care of children with specialist needs.

The RCPCH Medical Workforce Census 2015 has shown us that in Scotland, 71% of subspecialty services deliver planned work as part of a funded managed clinical network system<sup>1</sup>. During site visits, it became apparent that there is a more integrated approach to healthcare services in Scotland as opposed to the other nations. For example, Crosshouse Hospital (Kilmarnock) accessed specialist advice through a Regional Centre in Glasgow. As part of the managed network, the sub-specialties visit hospitals in the area to provide joint

clinics, ensuring specialist paediatricians are known and visible. The process has improved the education of general paediatricians, making them more capable to respond to specialist queries as patients present. The network management requires District General Hospitals (DGHs) to provide feedback on where children are receiving their care, to ensure pathways are appropriate, which has enabled children to receive specialist care locally.

Data revealed that access to specialist advice has worsened since the previous audit of the standards in 2013. This reflects variations in funding arrangements for the development of specialist services. Most units receive access to specialist advice and opinion through local tertiary centres. These links can be fragmented and informal, relying on personal, individual connections which are hard to sustain on a 24-hour, seven days a week basis. As a result, getting immediate advice can be challenging for general paediatricians that can result in delays for patient care.

Some units suggested that more work was needed to be done with specialist paediatricians to develop networked pathways of care. RCPCH recommends that generalists should work together with specialist paediatricians to foster relationships. Units who currently work through informal networks can work towards formalising these links.

RCPCH recommends that the development of formal networks between general and specialist paediatrics should be adequately funded by commissioners and service planners. The benefits of implementing standard 9 improves the level of care provided for patients and increases likelihood of compliance with other *Together for child health* standards. Guidance from *Bringing Networks to Life* and the *RCPCH and BSPGHAN Quality Standards* document are useful tools to drive quality improvement<sup>25,26</sup>.

## Practice Example

### University Hospital Southampton NHS Foundation Trust

The Wessex Paediatric Gastroenterology, Hepatology & Nutrition Network (WESPGHAN) provides an effective means of exchange of information that shares best practice and promotion of regional audits whilst providing continual development of services and care across Wessex. Since it was established in 2005, the Wessex network has grown to a membership of 13 hospitals including: Portsmouth, Chichester, Poole, Dorchester, Winchester, Basingstoke, Salisbury, Frimley Park, Isle of Wight, Guernsey, Jersey, Guildford and Southampton.

The Southampton paediatric gastroenterology (GI) team provides immediate telephone advice for acute problems pertaining to gastroenterology, hepatology and nutrition to paediatricians in the region, available 24 hours a day, 365 days a year. Acutely unwell children presenting with GI problems can be transferred seven days a week to be reviewed by the paediatric GI team in Southampton.

The 24/7 provision of immediate telephone advice has helped reduce delays in care meaning clinical issues are addressed quickly patient experience is improved. General paediatricians feel supported and reassured in their decision-making when they can easily access advice and guidance.

Alongside provision of acute services, Southampton paediatric GI team also provides visiting regional clinics in 7 regional hospitals (every 2-6 months). Each unit within the network, has a nominated lead (consultant with paediatric GI interest), providing a streamlined, direct and effective communication channel. This enables smooth delivery of care. Southampton has developed links with adult GI units from hospitals within the WESPGHAN network to improve transition pathways for young people.

WESPGHAN maintains a steady stream of communication between members of the network via their online website and forum. Members can readily access written support and advice for any queries including condition-specific care pathways, research, reports, educational resources and events are shared regularly. WESPGHAN members meet on an annual basis to discuss the needs of children and families within the region and any arising issues are dealt with collaboratively.

View the WESPGHAN website: <https://www.networks.nhs.uk/nhs-networks/wessex-paediatric-gastroenterology-hepatology>

Contact detail: Nadeem Ahmad Afzal, Consultant in Paediatric Gastroenterology, [N.Afzal@soton.ac.uk](mailto:N.Afzal@soton.ac.uk), Southampton Children's Hospital.

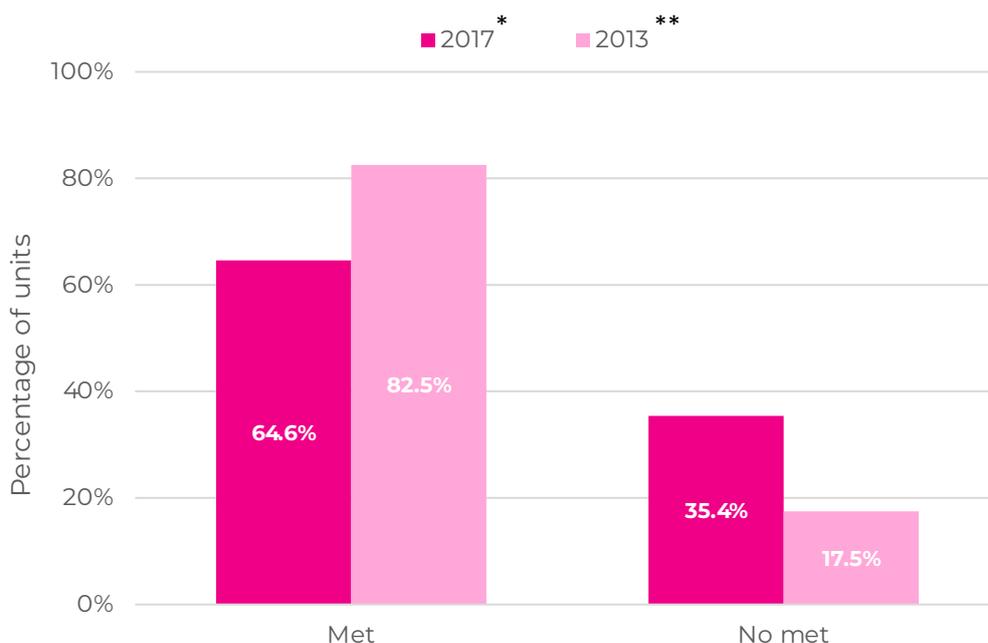
## Standard 10

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.

### Headline results

In 64.6% of units, all children, children’s social care, police and health teams have access to a paediatrician with child protection experience (of at least level 3 safeguarding competencies) and skills to provide immediate advice and assessment for children where there are child protection concerns.

**Figure 10: units that offer level 3 safeguarding advice and assessment (comparison with 2013)**



\* 2017 n = 95; data missing or unknown for 18 units

\*\* 2013 n = unknown missing data

The RCPCH Intercollegiate Document outlines the training and competences for staff members working with children, to appropriately identify child maltreatment and take actions accordingly. The document specifies that Level 3 safeguarding training should be met by all ‘clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating

the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns<sup>27</sup>.

Health organisations have a duty to work together with social services to safeguard children<sup>28</sup>. This standard promotes inter-agency cooperation to ensure child protection concerns are addressed collectively.

Units who are meeting standard 10 will have named doctors/ nurses within their hospitals and equivalents within community settings, who provide expert opinion and guidance. Though access to this is not routinely available on a 24/7 basis, some units have developed child protection rotas and child protection on-call services. In units with successfully embedded safeguarding teams, they offer a point of contact for professional queries and can also provide in-house training.

Multi-professional working is being successfully implemented in many units. Clinical leads noted benefits of regular safeguarding supervision meetings with leads from different agencies as a method of peer review. Successful units are routinely notifying all healthcare professionals involved in the care of a child if child protection status changes, while some exceptional units are drafting the child care plans in conjunction with social services. It was noted, however, that where regular care plans were drafted with paediatric input there had been a considerable increase in workload, which was not necessarily supported through an increased workforce.

However, not all units had developed effective working relationships with external colleagues with some clinical leads highlighting the benefits of including paediatricians in the development of care plans with police and social care professionals. It was noted that agencies may be unaware that the consultant on-call can offer advice and guidance.

Specialist child protection advice was frequently available through community paediatric services, commonly operating during the hours of 9am to 5pm. For hospital based paediatricians, covering evening, overnight and weekend child protection duties can exacerbate workloads and discussions around extending community paediatrician input with this duty was noted throughout most sites visited. In some cases, it was reported that social services and the police were unaware of the working hours of specialist community paediatricians and would demand child protection medicals that consultants could not provide during the night.

Units reported that wards or paediatric assessment units may be inappropriate settings for children presenting with suspected bruising or child sexual abuse, particularly in locations where a designated child protection suite is unavailable. As such, it was queried whether the needs of this group of children are better served within community settings.

Closer working between hospital and community settings is recommended to promote a supportive and collaborative approach to child protection and safeguarding. Services that were meeting this standard particularly well have advised that enhancing specialist child protection skills and training for consultants, with opportunities for frequent shared learning with community paediatricians is key to fostering collaboration.

## **Practice Example**

### **Statement developed by the RCPCH Child Protection Standing Committee**

*“Standard 10 ensures that the necessary competencies for assessment and advice are maintained for all relevant professionals. Where there are child protection concerns, it is important for detailed assessments to be undertaken and supported with written documentation. Where necessary, further investigations should be planned and discussed with the child’s parents / carers before the child is discharged. Compliance with this standard ensures that all potential child safety concerns are dealt with in a timely and effective manner. Furthermore, the standard fulfils the recommendations of Lord Laming’s Victoria Climbié Inquiry, which states that any child admitted to hospital with possible safeguarding concerns has a consultant led or consultant supervised assessment as soon as possible .*

*Units should strive to develop a local child safeguarding strategy, which should include detail on how individual paediatricians can access support and advice to aid compliance with this standard. Regular peer review and individual supervision is encouraged to maintain high levels of good practice.*

*Effective pathways and communication between general and community paediatrics will enable children to be seen in a timely manner, within appropriate settings. For example, Paediatric Sexual Assault Referral Centres (SARCs) provide a suitable location for the assessment of children with suspected child sexual abuse (CSA).*

*Ultimately, compliance with standard 10 protects children who are vulnerable to child protection concerns, providing access to safe and supportive assessment and advice from appropriately trained professionals.”*

**Dr Geoff Debelle, RCPCH Officer for Child Protection, February 2018**

## Understand &Us

In 2017, Scott, 17 (Llanharan Drop In) and Alex, 18 (Scottish Youth Parliament) co-created a new model based on RCPCH &Us consultation responses from over 200 children and young people, to help healthcare professionals to think about their work with children and young people. This was presented to the Royal College of Emergency Medicine at the adolescent study day to help people working in acute services to think about key things to remember to do or say or think about when children or young people are in health crisis or acute situations.

### Their top tips using the word 'Understand' are:

<b>U</b>	<b>Us.</b> Who is the patient? Talk to <b>Us</b> and not just our parents or carers.
<b>N</b>	<b>Numbers matter.</b> Missed opportunities to find out more or to actively listen to <b>Us</b> .
<b>D</b>	<b>Disclosure.</b> We want to know who has to know, who needs to know and ask <b>Us</b> who do I want to know.
<b>E</b>	<b>Environment.</b> Is it a child/youth friendly waiting area/consultation space so that I feel comfortable to talk with you about what has happened?
<b>R</b>	<b>Reassure Us</b> that you have listened, heard and acted on what we have said.
<b>S</b>	<b>Signposting.</b> Do you know your local child/youth support services? Help <b>Us</b> to get support once you have gone.
<b>T</b>	<b>Transition.</b> Within hospitals / GPs and other services should include <b>Us</b> in the conversation and planning.
<b>A</b>	<b>Attitude.</b> A smile costs nothing but makes <b>Us</b> feel like we matter.
<b>N</b>	<b>Needs.</b> Find out what matters to <b>Us</b> this could be how or where we are treated, who we want to be with <b>Us</b> .
<b>D</b>	<b>Decisions.</b> Need to involve <b>Us</b> . Article 12 from the United Nations Convention on the Rights of the Child helps <b>Us</b> to have access to best healthcare possible, Article 24.

To find out more about this model go to [www.rcpch.ac.uk/Superhero](http://www.rcpch.ac.uk/Superhero) and download the Understand worksheet.

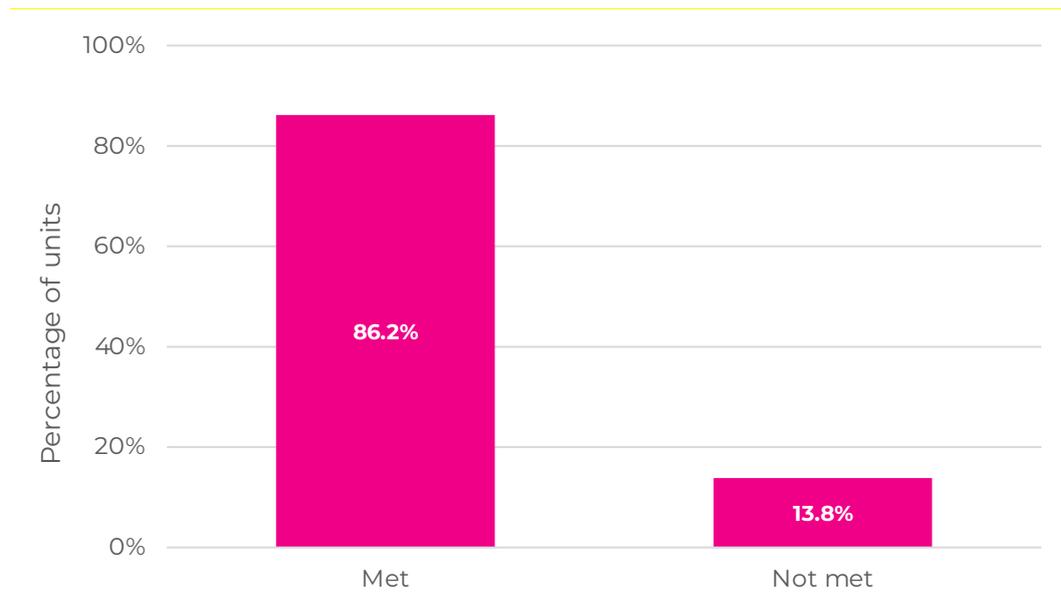
## Standard 1 Together for child health

GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.

### Headline results

GPs have access to immediate telephone advice from a consultant paediatrician in 86.2% of units.

**Figure 11: Percentage of units that offer immediate telephone advice to GPs**



n = 94; missing or unknown = 19

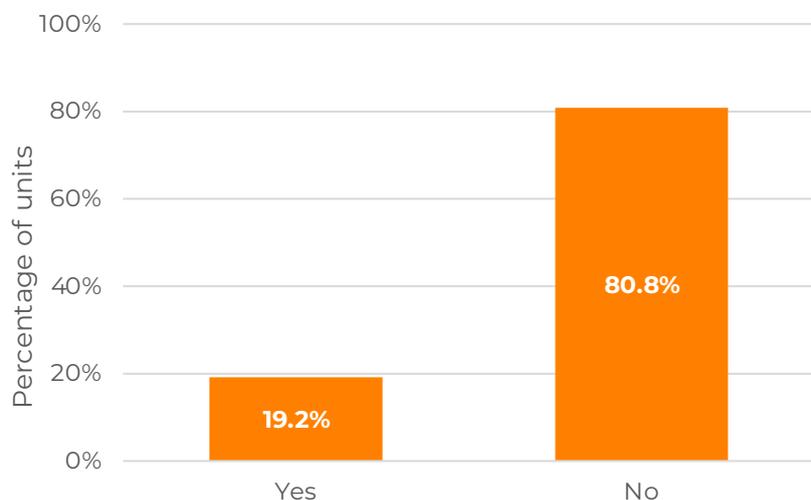
Around one in three GPs in the UK have post-graduate specialist paediatric training with little undergraduate exposure to paediatrics<sup>30</sup>. Given this context, it is hardly surprising to see such positive uptake of a service to link paediatric advice into general practice. Site visits have shown us the varying ways in which GPs can access immediate advice from a consultant paediatrician; most frequently via a dedicated 'hotline' or mobile phone; a bleep system; or through the hospital switchboard. Where some paediatric services felt uptake of the dedicated telephone advice service was not fully utilised by GPs, access to advice has matured to other channels, such as through a dedicated email or clinical portal/ clinical e-referral system.

Establishing dedicated telephone lines can be challenging, and site visits have highlighted the need for services to negotiate through somewhat complex existing IT infrastructure, commissioning arrangements and moreover than not, making GPs aware of the service to ensure it is used.

Where GP hotlines have been established successfully, relationships between the GP and paediatric service have been strong with GPs reaping the benefits of accessing immediate advice. We have seen examples where ‘hotlines’ have been used to support GP registrars and newly qualified GPs with positive feedback.

However, the audit results show that only 19.2% of those that offered telephone advice services are funded. Whilst services told us that the benefits of providing the service far outweigh the financial implications, services are struggling to obtain consultant time to enable telephones to be manned whilst seeing patients and leading ward rounds. In order to extend the operative hours of the service to align with the opening times of general practice, additional consultant cover will be required.

**Figure 12: Percentage of units who have a commissioned telephone ‘hotline’ service for GPs to a consultant paediatrician**



\* n = 73; missing or unknown = 8  
 Data note: only services that are subject to commissioning arrangements answered this question.

## **Practice Example**

### **GP Hotline service at Wexham Park Hospital, Frimley Health NHS Foundation Trust**

Wexham Park has run a GP hotline service since 2010 that is set up for GPs to call for advice on outpatient avoidance for one hour every day. The hotline was open to midwives and nurse practitioners, though predominantly used by GPs and GP trainees.

Between May 2016 and March 2017, the hotline service was extended to operate between 9am to 10pm on weekdays and 9am to 5pm on weekends. Consultant advice was available for any subject matter, not solely for admission avoidance. The service was used by 70 different GP practices in the region and over this period, a total of 722 calls were made with 272 of those calls made between midday and 2pm.

Data collected showed real benefits of establishing a GP hotline service. Of those calling for admission avoidance, 50% were given advice requiring no follow-up and for those calling for outpatient department avoidance, 67% were given advice requiring no follow-up. Furthermore, of the GPs calling for clinical advice, 75% were given advice requiring no follow-up. These figures illustrate how consultants are enabled to control the flow of patients into their units in addition to ensuring that children are seen at the right time, in the right place, by the right person.

Despite the notable success of this service, Wexham Park returned to providing the GP hotline for one hour each day. Successful long-term implementation requires funding for consultant-cover and Wexham Park has been able to secure funding and the appointment of an additional consultant to expand the service later this year.

Contact: Dr Jo Philpott, Consultant Paediatrician, Wexham Park Hospital  
[Joanne.Philpot@fhft.nhs.uk](mailto:Joanne.Philpot@fhft.nhs.uk)

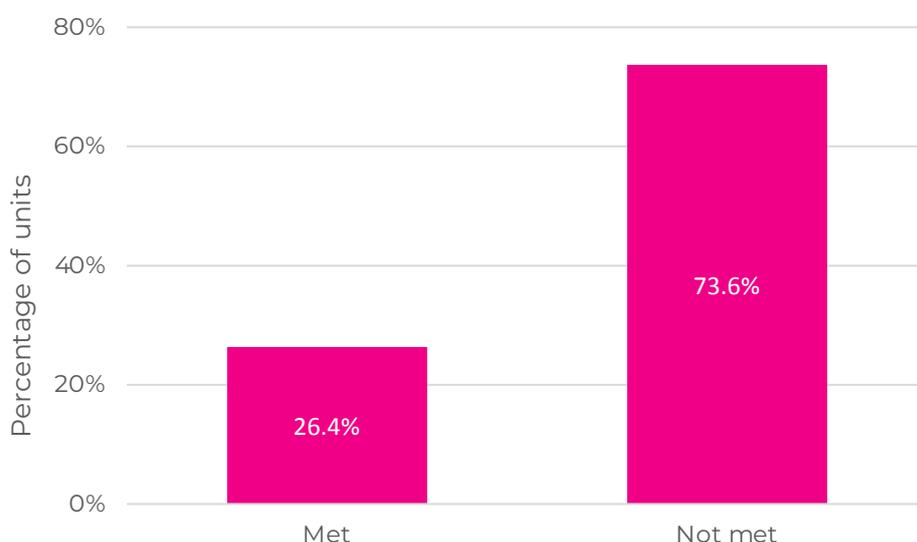
## Standard 2 Together for child health

Each acute general children's service provides a consultant paediatrician-led, rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.

### Headline results

26.4% of acute general children's services provide a consultant paediatrician-led rapid-access service so that any child referred can be seen within 24 hours.

**Figure 13: Percentage of acute general children's services with a consultant paediatrician-led rapid access service where CYP are seen within 24 hours**



\* n = 91; missing or unknown = 22

Whilst a 73.6% of units did not meet this standard, commentary from the survey revealed there is large variation in the way rapid access clinics are held. The majority of these units had clinics that ran from one to 5 times per week, meaning that children can be seen up to 72 hours from the time of referral. There were few units that did not specifically hold rapid access clinics but had provisions for children to be seen quickly either in their own urgent clinics, PAU or in the wards.

Site visits have shown great variability in establishing effective rapid access clinics. Visits to services in England have shown us examples where clinical leads felt the clinics were not properly utilised; in some instances inappropriate referrals were being made in order to fast track patients into secondary care which exacerbated wait times preventing the service from being able to see children within 24 hours. Clinical leads frequently asked for clarity regarding the most effective criteria to use to ensure that children with the correct acuity and/or conditions were being rapidly seen. Within the standards' guidance, it was recommended that criteria should be developed locally. However site visits showed us

examples where variations in clinical judgement and what constituted a referral that required 'rapid' review had negatively impacted the principles behind the standard.

Site visits highlighted that on the surface, units that struggle to meet this standard are challenged by defining criteria to accept appropriate referrals. For paediatricians, the most successful examples of a rapid access clinic were when GPs and other referring health professionals contacted the paediatric team prior to referring the child, enabling the consultant paediatrician to manage patient flow, perform initial triaging and to share expertise with the primary care professional.

There is general consensus that rapid access clinics provide reassurance for parents of children with acute, unscheduled care needs and when utilised well, can support safety netting and admission avoidance<sup>31</sup>. Consultants and GPs felt that a rapid access clinic whereby a GP can directly contact the consultant (see standard 1 *Together for child health*) instead of using pathways to refer children in can work well. Further commentary on developing shared care pathways for children with unscheduled care needs is included within standard 11 of *Together for child health*.

### **Practice Example**

#### **Hillingdon hospital NHS Trust**

The hot clinic was set up with the paediatric assessment unit (PAU) in September 2016 with the purpose of preventing children from attending A&E. The clinic is located within the PAU and is held during off-peak hours Monday to Friday between 9.30am and 10.30am with three appointments which are 20 minutes each. The clinic is part of the acute consultant's job plan, in which they gatekeep the appointments and the referrals ensuring children are correctly referred into the clinic. Referrals are made via GPs and other healthcare professionals by telephone where they can discuss the child and the consultant will usually book the child to be seen the next day.

The service is well received by GPs and other healthcare professionals as it provides rapid access to a consultant for any child that is failing to thrive or any acute conditions that have not shown any improvement.

Further details: Dr Jaikumar Ganapathi, Consultant Paediatrician and Clinical Lead, [jaikumar.ganapathi@nhs.net](mailto:jaikumar.ganapathi@nhs.net)

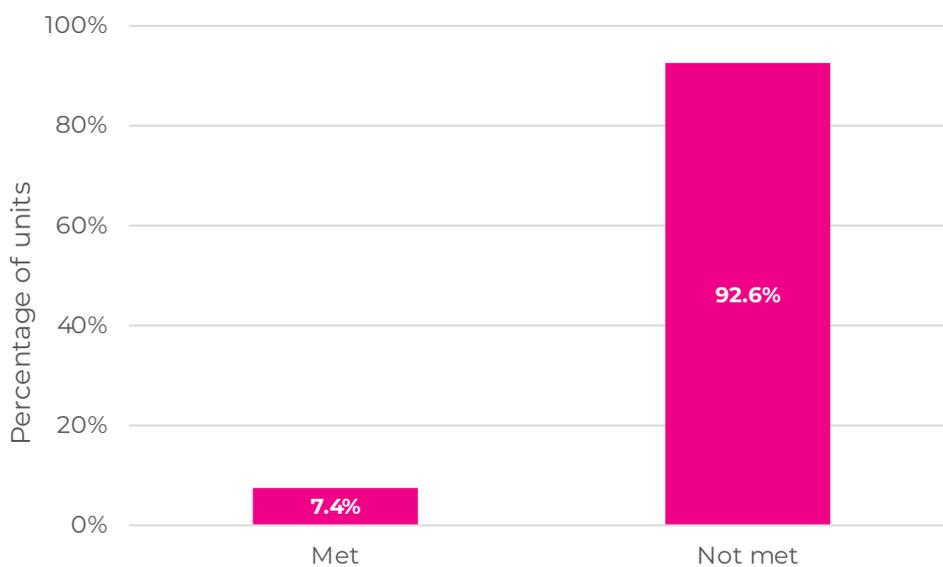
## Standard 3 Together for child health

There is a link consultant paediatrician for each local GP practice or group of practices.

### Headline results

7.4% of paediatric units reported having a link consultant paediatrician for each GP practice or group of practices.

**Figure 14: Percentage of units that have a linked paediatrician to each local GP practice or group of practices**



\* n = 94; missing or unknown = 19

With increased fragmentation of services and the impact of commissioning arrangements changing at rapid pace, it is all the more important for links to be made between general practice and children's health services. Links ensure pathways of care allow children to be managed well within the community. Auditing this standard has shown poor results, and site visits have revealed the barriers for meeting this standard are due to organisations working in silos and issues with capacity, particularly for colleagues working in primary care.

Clinical leads are positive about arranging links with GPs, with some paediatric services in England reporting that they are commissioned to make the link. However, many GPs do not have the time and resource to build these relationships and are unable to get cover in their practice to enable them to attend paediatric meetings. GPs report that the majority of focus is on meeting the needs of adults, particularly the elderly population, which can impact on their ability to develop collaborations with child health clinicians.

There are some practices that do recognise that children make up a substantial portion of their patient list size and are aware of the importance of engaging with paediatric services. However, due to the increasing work pressures of GPs, paediatricians require evidence to demonstrate the effectiveness of linking a consultant paediatrician with each GP practice or group of practices. The practice example included within this document for standard 4 of *Together for child health* demonstrates the benefits of linking GPs with paediatricians.

**Practice Example**

See Practice Example for Standard 4 *Together for child health*.

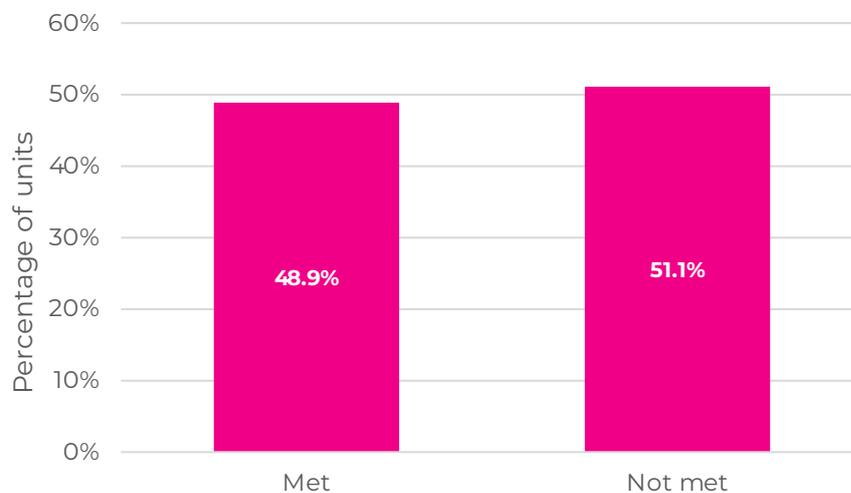
## Standard 4 Together for child health

Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.

### Headline results

48.9% of acute general children's services provide biannual education knowledge exchange sessions with GPs and other healthcare professionals.

**Figure 15: Percentage of units that provide biannual education and knowledge exchange sessions with GPs and other healthcare professionals**



\* n = 90; missing or unknown = 23

Less than half of GP trainees undertake a paediatric placement<sup>32</sup>. Creating strong relationships between paediatricians and primary care is key to delivering high quality care for children, given children can account for 25% of the patient population for GPs and it is most likely that children and their families will want to contact their GP first for any unscheduled care needs<sup>33</sup>.

Increased pressure on general practice has impacted poorly on GPs' availability to attend education sessions. GPs have told us that resource needed to cover their clinical duties is not easily available and paediatricians have reported that attendance rates for these activities can often be poor.

There have been successful examples where education sessions are provided by the paediatric service, but often arrangements are made informally and meetings are not structured with any meaningful frequency. In order for services to fully integrate, service planners and health organisations must ensure links between primary and hospital services is protected in order to improve pathways of care and support hospital avoidance strategies.

## **Practice Example**

### **Education Sessions as part of Integrated Care for Children at Tameside and Glossop Integrated Care NHS Foundation Trust**

The paediatric team of Tameside Hospital has developed an initiative to provide education and knowledge exchange sessions with GPs in five locally identified neighbourhoods as part of the Integrated Care for Children programme, working to integrate services for children residing in the surrounding areas of Tameside in Greater Manchester, and the town of Glossop in Derbyshire.

Two acute paediatric consultants and two community nurses are affiliated to each neighbourhood. Once a month, the link consultant and link nurse visit one of their neighbourhood GP surgeries, ensuring each surgery is visited at least twice per year (see standards 3 and 6 of Together for child health). These are provided as bespoke educational sessions with GPs and their practice nurses. The sessions last between one and two hours and the paediatric team will, for example, present cases that have been referred to clinic by that particular practice. This works in synergy with the Electronic Advice and Guidance System which was established to support GPs and patients with a subsequent reduction in hospital clinic appointments of 30%. The system was developed and endorsed in conjunction with patient user groups.

GPs and their practice nurses attend on the day to discuss cases for which they require paediatric advice. Clinical governance is maintained by the GPs with the support of paediatricians writing summary letters. The education and knowledge exchange sessions enable the paediatric team to understand GPs' patients within the context of primary care. Patients benefit from the scheme by consultant paediatric expertise being brought to the front end of the care pathway, whilst GPs and practice nurses are skilled up and more confident in managing children in primary care, that over time will work to reduce referrals to the paediatric service.

Education sessions provide opportunities to build relationships between primary healthcare professionals and the paediatric team. Not only does this encourage GPs to contact their paediatric team for advice and guidance, as per standard one of Together for child health, but it facilitates opportunities to develop shared care pathways and guidelines (see standard 11 of Together for child health).

Looking forward, the vision for the paediatric team at Tameside Hospital is to nominate GP champions for each neighbourhood to work with consultant paediatricians and community nurses who have oversight of each neighbourhood district to bring together a meeting with a governance structure that meets quarterly to feed into hospital plans as part of the wider Integrated Care for Children programme. This enables local systems to have a process in place to both review and implement improvements including care

pathways, risk management and safeguarding (see standard 10 of Together for child health).

Further details: Dr David Levy, Clinical Lead [David.Levy@tgh.nhs.uk](mailto:David.Levy@tgh.nhs.uk) and Dr Adam Armitage, Consultant Paediatrician [adam.armitage@tgh.nhs.uk](mailto:adam.armitage@tgh.nhs.uk), Tameside and Glossop Integrated Care NHS Foundation Trust.

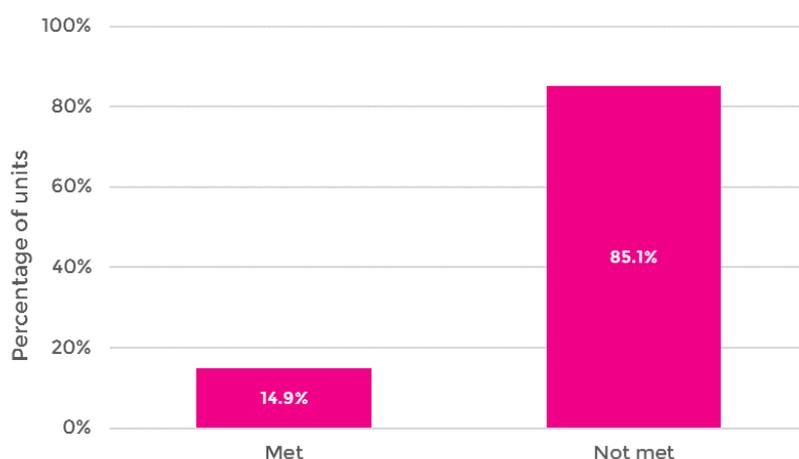
## Standard 5 Together for child health

Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.

### Headline results

14.9% of acute general children's services are supported by a community children's nursing service that operates 24 hours a day, seven days a week.

**Figure 16: Percentage of units with a linked community children's nursing service that operates 24 hours a day, seven days a week.**



\* n = 94; missing or unknown = 19

Children's nursing teams are a key component of integrated children's services and sites visited during the audit overwhelmingly reflect the value that community nursing brings to caring for children using the whole-pathway approach. However, site visits showed great variability in the types of children's community nursing (CCN) teams available; both in relation to their role and the hours they provide the service. As presented in figure 17, respondents in the audit reported that the majority of CCNs operate less than 12 hours per day.

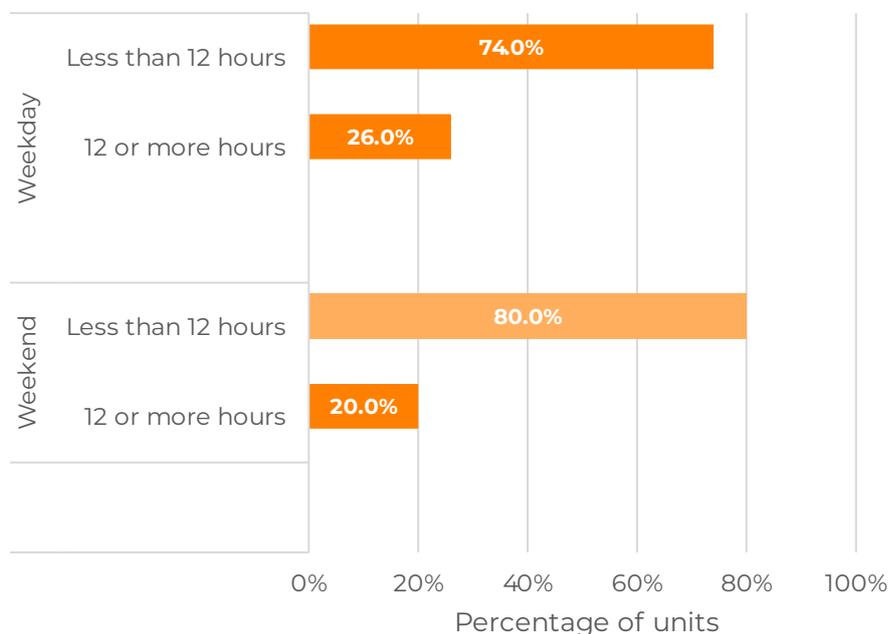
Anecdotally, nurses have described examples where services have been decommissioned as a result of low use during out of hours. Nurses are therefore providing duties to their patients out of goodwill, that are not recognised in service specifications and workforce planning<sup>34</sup>. Department for Health guidance has clearly stated that children should have access to visits from a children's community nursing team at home between 8am and 10pm with 24 hour telephone advice available<sup>35</sup>.

Clinical leads tell us that the acute paediatric service has little say in what nursing services are provided or linked with their service, and that geographical service boundaries often

impact what services are available, especially if the nursing service covers several catchment areas. The financial viability of meeting this standard was raised as an issue by the majority of units visited and shortages in registered children’s nurses has made it difficult to recruit into expanding nursing teams, which may indicate why services are in the majority of cases operating a service between 9am and 5pm. Whilst workforce issues have been recognised as a huge challenge, there has been a 15% increase in full time equivalent numbers for children’s nursing in 2017<sup>36</sup>. Creating networks or collaborative working between commissioners and health boards could be a potential solution to tackle the catchment area issue with crossing boundaries.

The RCPCH will be working closely with the Royal College of Nursing to better understand and recommend how services can meet this standard.

**Figure 17: Number of hours community nursing services are operational**



\* Weekday n = 73; missing or unknown = 40

\* Weekend n = 30; missing or unknown = 83

## **Practice Example**

### **South Staffordshire Service – Community Children’s Nurse teams, East and West Locality**

The South Staffordshire Community Children’s Nursing team contains two teams that cover the west and east areas of South Staffordshire. Both teams provide a service that aims to prevent hospital admissions, facilitate early discharge and provide care at home for children with acute illnesses. They also support families caring for children with long term conditions, which involves advising and teaching families how to care for children at home as well as assessing and planning care plans with families. The service provides 24/7 support for children at end of life in addition to eight phlebotomy clinics and four nurse led constipation clinics per month.

The west nursing team is staffed by 7.2 whole time nurses that offers a service seven days a week, between 9am and 9pm. The service operates under a single point of access to receive referrals from GP, hospital based children’s services and health visitors and for children with acute illness, the service aims to contact the family within three hours of receiving the referral.

Nurses triage referrals by telephone assessment to determine if a home visit is required or to provide advice and support over the phone. The latter is supported by emailing care plans for common conditions to parents. The rota allowed for two staff on shift or by operating a buddy system.

Further details: Alison Totty, Team leader/ Paediatric Advanced Nurse Practitioner, Community Children’s Nursing team [Alison.Totty@sssft.nhs.uk](mailto:Alison.Totty@sssft.nhs.uk)

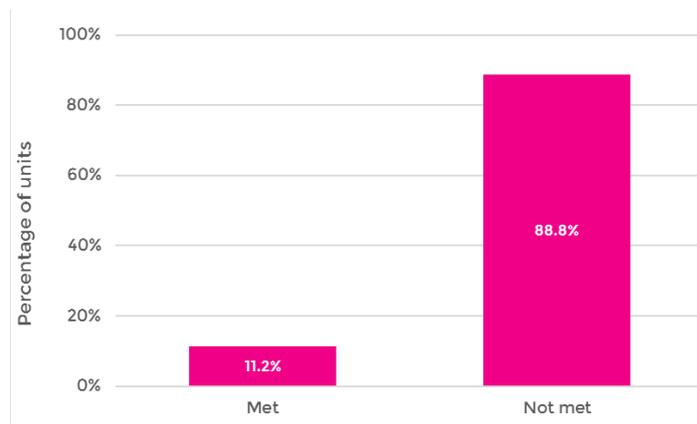
## Standard 6 Together for child health

There is a link community children's nurse for each local GP practice or group of GP practices.

### Headline results

11.2% of GP practices are linked with a community children's nurse.

**Figure 18: Percentage of GP practices that are linked with a community children's nurse.**



\* n = 89; missing or unknown = 24

There were numerous challenges in meeting this standard, reported by clinicians attending our site visits. Community children's nursing (CCN) teams lack the resources stemming primarily from the shortage of children's nurses, meaning that many CCN teams lack the time to build these key relationships. Pressures on GPs in primary care can often result in poor opportunities for CCNs to engage with general practice. Service planners must ensure links are created to ensure GPs are aware of the services that children's community nurses can provide as means of support, particularly when working to avoid unplanned admission.

The challenge in monitoring progress towards this standard was in the acute paediatric service not always knowing the arranged links between community children's nurses and local GP practices. Links with a CCN team, rather than with a named individual, would be more sustainable to consider increasing service demands, capacity in teams and rota arrangements. The nurses and GPs that were spoken with during site visits felt it would be more realistic to link CCN teams with a locality or 'hub' of GP practices. A central point of access or a CCN team email address would be a sufficient means of contact for GPs.

#### Practice Example

See practice example for Standard 4 Together for child health.

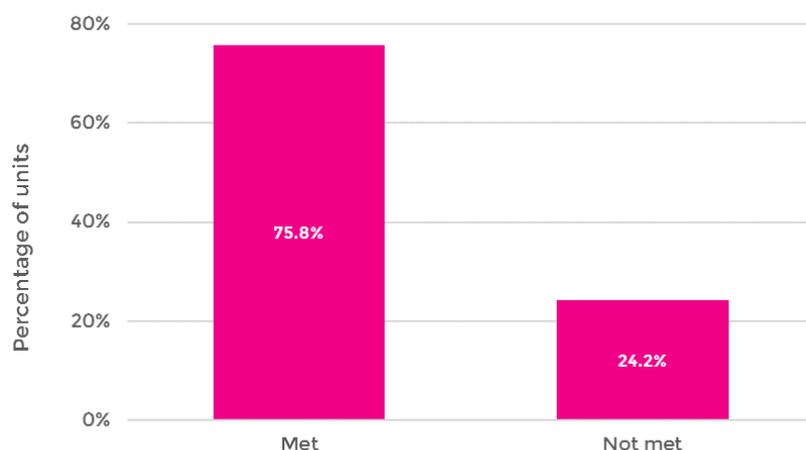
## Standard 7 Together for child health

When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.

### Headline results

75.8% of children's acute services send the discharge summary electronically to the child's GP and relevant health professionals within 24 hours with information given to the child and their parents and carers.

**Figure 19: Units that provide an electronic discharge summary to GPs and other healthcare professionals within 24 hours with information given to children and parents**

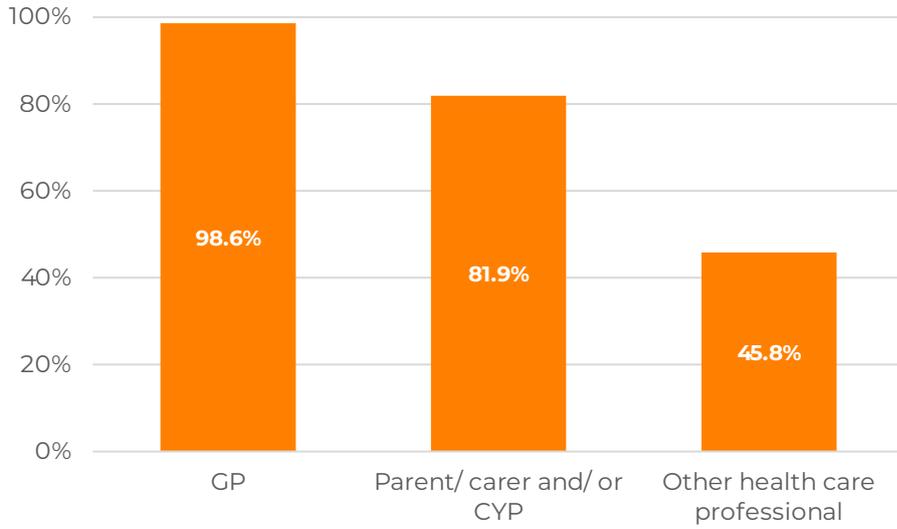


\* n = 95; missing or unknown = 18

Discharge summaries are an essential form of communication between hospitals and primary care services, particularly for GPs as it provides important information to enable onwards care and management of patients, including any diagnosis and information around medication.

Poorly resourced IT infrastructure across health services and a lack of interoperable systems, often means services are not meeting this standard. Cuts to administrative and secretarial staffing can also impact poorly on information being shared in a timely manner. Units are most likely to meet this standard if they have access to electronic health records between primary, secondary and community services.

**Figure 20: Healthcare professionals that are sent discharge summaries electronically**



\* n = 72; missing or unknown = 1

### Practice Example

Professional Records Standards Body eDischarge summary

The RCPCH has endorsed guidance developed by the Professional Records Standards Body on standards for organising information on discharge, a key component of improving patient safety and ensuring continuity of care.

Guidance is available <https://theprsb.org/standards/edischargesummary>

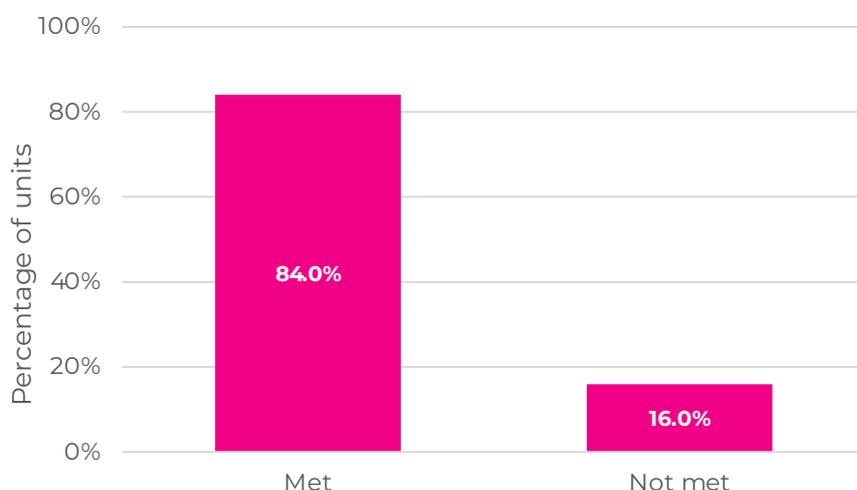
## Standard 8 Together for child health

Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.

### Headline results

84.0% of units provide verbal and written safety netting information to children and their parents upon discharge.

**Figure 21: Percentage of units that provide both verbal and written safety netting information**



\* n = 94; missing or unknown = 19

Providing written and verbal discharge information increases the knowledge and satisfaction of children and families using health services<sup>37</sup>. Site visits showed us that there is great variability in the quality of written information available with further inconsistencies dependent upon the diagnosis or condition. Healthcare professionals reported that they felt confident that they are providing verbal information to children and their families, and check that they understand what to do if the child's condition deteriorates or if they need to contact the health service out of hours. However, access to quality written information, in a language that is understood and clear to the child, can often be a barrier to meeting this standard.

Auditing this standard has benefited from input from the &Us Young Inspectors who assisted with visiting paediatric services across the UK. We know that children and young people are increasingly accessing information on their health in digital formats<sup>38</sup>. Keeping information up to date, evidence-based and accessible is a constant challenge but an essential component of providing good health care. The presentation of a child in the unscheduled care system can often present as an opportunity for health promotion and

education on illness and safety practices and health professionals must take every opportunity to interact with children and their families on these issues.

### **Practice example**

The RCPCH &Us Young Inspectors who were involved in auditing this standard have developed a tool for healthcare professionals to think about what matters most to children and young people when they present to hospital with unscheduled care needs. Find this on page 71.

For more information on the &Us Young Inspectors Programme please contact [and\\_us@rcpch.ac.uk](mailto:and_us@rcpch.ac.uk).

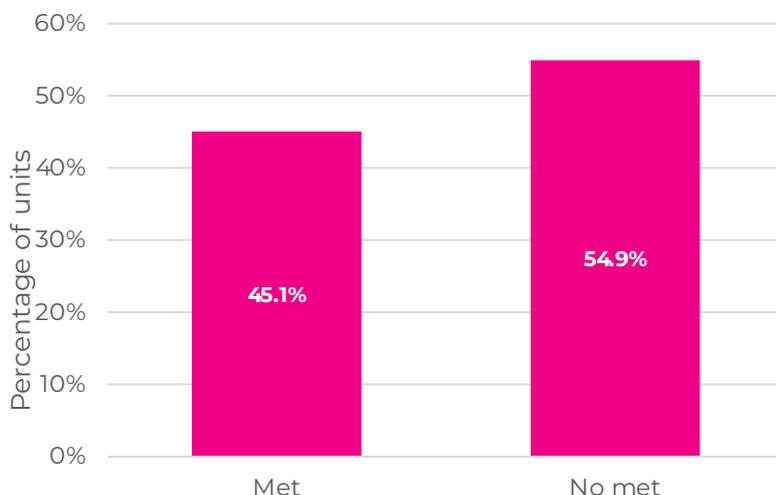
## Standard 9 Together for child health

Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child’s shared electronic healthcare record.

### Headline results

45.1% of paediatric services report that healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child’s shared electronic health record.

**Figure 22: Percentage of units that have access to a child’s shared electronic healthcare record**



\* n = 91; missing or unknown = 22

A recent survey showed that 72% of patients said they would prefer digital communications from their healthcare provider over those sent via post<sup>39</sup>. Whilst progress is being made in Wales by way of developing the Welsh Care Record Service and Welsh Clinical Communications Gateway, England falls behind in promoting national standards and an investment towards sharing access to health records. Learning must be taken from Northern Ireland.

*“Northern Ireland has NIECR – it is the single biggest improvement to healthcare in Northern Ireland over the previous few years. We are no longer dependent on patient’s paper charts, meaning there are fewer delays. We are able to review and assess patients more efficiently because we aren’t constantly waiting for the last set of notes. This has improved the work of doctors and nurses, which has importantly improved the level of care provided for our patients.”*

Andrew Sands, Clinical Director at Belfast Health and Social Care Trust

It is hardly surprising to hear the frustrations echoed by health professionals across the UK who struggle to access vital information for

the children they care for. Accessing information easily can inform better clinical decision making, reduce the need to repeat investigations and prevent duplications of work.

The varied planning and commissioning arrangements in health services across the NHS means that the development and implementation of interoperable information systems are challenging to progress. Work is ongoing within each nation to develop and optimise digital health strategies that should work to support an improvement in this standards' compliance by the next *Facing the Future* audit scheduled for 2020<sup>40-43</sup>.

### **Practice example**

#### **Northern Ireland Electronic Care Record (NIECR)**

The Northern Ireland Electronic Care Record (NIECR) has been operational since May 2013. The shared electronic health record allows all Health and Social Care staff access to the following patient information:

- Personal information (name, address, date of birth, Health & Care number, hospital number, GP details)
- 'Encounters' with healthcare settings and scheduled future appointments
- Referral letters, discharge letters and any other clinical correspondence
- Allergy information
- Medications prescribed
- Laboratory test and x-ray results.

Development of NIECR has ensured effective communication and delivery of patient care, meaning that the right information is available in the right place at the right time.

Further information: [www.ehealthcare.hscni.net](http://www.ehealthcare.hscni.net)

Contact detail: [ehealthandcare@hscni.net](mailto:ehealthandcare@hscni.net)/ 0300 555 020

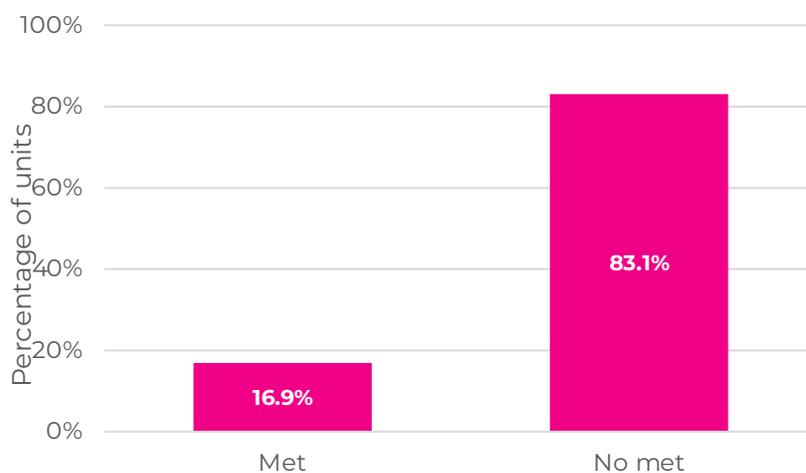
## Standard 10 Together for child health

Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.

### Headline results

16.9% of acute general children's services report working together with local primary care and community services to develop care pathways for common acute conditions.

**Figure 23: Percentage of units that report working with primary care and community teams to develop shared care pathways**



\* n = 59; missing or unknown = 54

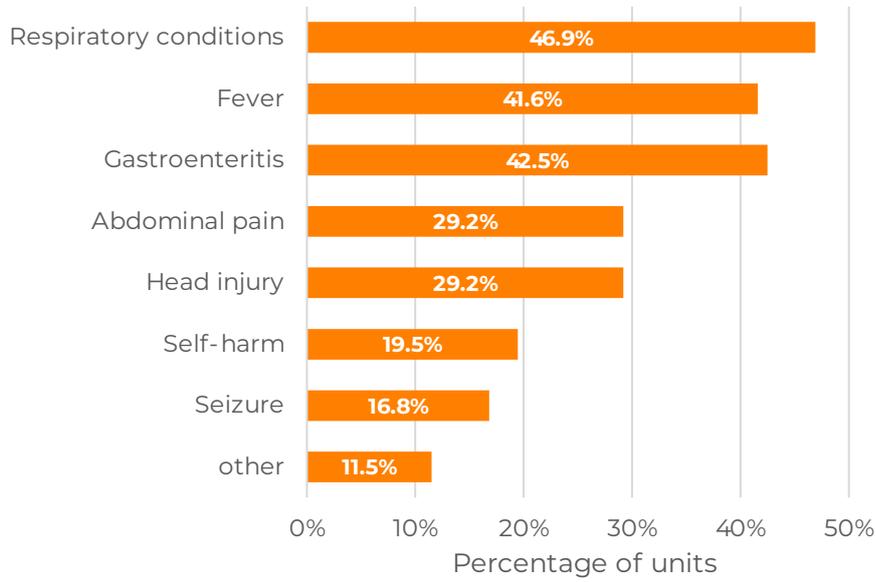
Developing pathways collaboratively with colleagues in primary, community and hospital care settings is undoubtedly a huge undertaking, which may go to explain the small number of hospitals who are able to meet this standard. Meeting this standard requires sites to have developed pathways for a minimum of eight conditions as presented in Figure 25 below, though we have seen examples where services have identified their most common presentations to the emergency department and worked to develop pathways for those conditions, as shown in the practice example below.

Sites tell us that it is not just about developing care pathways, it is about how sites are embedding and using pathways that will benefit the child across the whole pathway. Some acute services described examples where a huge amount of resource was put into developing pathways, but because of time restraints, it was not possible to progress such work.

GPs have told us that it can often feel like care pathways 'trickle down' and sometimes the sheer volume of information and changes to pathways can cause confusion. Pathways have the most impact when they are written collaboratively so that primary health professionals, nurses and the hospital service are using the same assessment tools and

benefitting from children using the correct pathway. The accompanying practice example included here demonstrates how pathways can be used to inform service design and delivery and how training provided by the acute service can support implementation of pathways.

**Figure 24: Conditions where pathways are developed**



\* n = 59; missing or unknown = 54

## Practice Example

### **Clinical Assessment Tools, Luton and Dunstable University Hospital NHS Foundation Trust, Cambridge Community Services and Luton Clinical Commissioning Group**

In 2015 Luton was chosen as a pilot site for an NHS initiative called Children and Young People's Rapid Improvement programme. Sites were asked to identify the common conditions presenting to urgent and emergency care settings and to develop pathways for those conditions. Seven conditions were identified and clinical assessment tools written for fever, bronchiolitis, gastroenteritis, asthma, head injury, seizure and abdominal pain collaboratively with Cambridge Community Services, Luton & Dunstable Hospital and Luton Clinical Commissioning Group.

All tools are reviewed annually or as and when new guidance is updated with engagement from the appropriate clinical teams. Parent advice leaflets have been developed alongside clinical assessment tools and engagement with parents has informed improvements. These are available for parents in written format as well as on local websites and social media.

In 2011 an education and training programme was developed for staff who work across the paediatric care system including staff who work in paediatric assessment units (PAU), emergency departments (ED) and providers of community and primary care. The three day training programme, known as the Children's Assessment, Knowledge and Examination Skills (CAKES) course, is delivered by consultant paediatricians and includes an OSCE and written exam. The training focuses on the seven tools to increase confidence in assessment for care prioritising and to embed the use of the tools in practice. A bite-size course was run for GPs to encourage engagement given pressures in primary care.

In 2013 the Children's Rapid Response Team was set up to receive referrals from the PAU, children's inpatient wards, ED, GPs, ambulance service and the children's community nursing team. The service is clinically led by nurse practitioners to support ED and hospital avoidance and facilitate early discharge. Referral criteria for this service is underpinned by the seven clinical assessment tools and clinicians must identify whether the child is green, amber or red on the pathway. This has helped to embed tools into clinical practice across hospital, community and primary care settings. Currently the service operates in the community but work towards moving the service to a clinic setting is anticipated, alongside opportunities to expand the service to take referrals from NHS 111.

Further details: Lynn Fanning, Children's Community Nurse Practitioner, Luton Children's Rapid Response Team [lynn.fanning@nhs.net](mailto:lynn.fanning@nhs.net)<sup>1</sup>

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<sup>1</sup> Luton and Dunstable University Hospital NHS Foundation Trust were included as a practice example for standard 10 of Facing the Future: Together for child health.

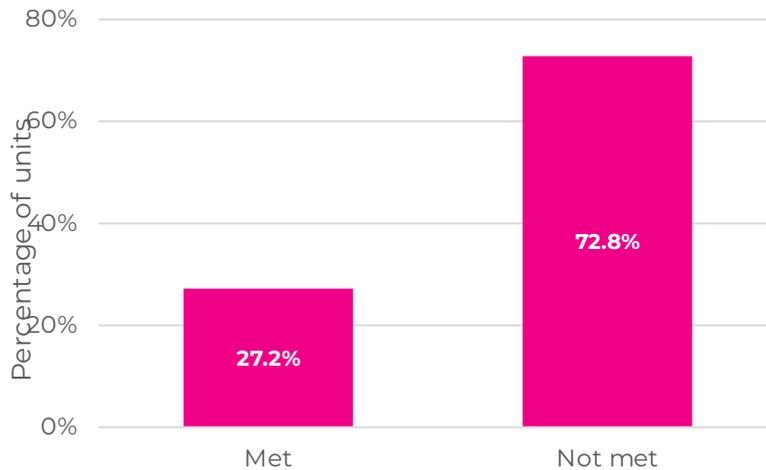
# Standard 11 Together for child health

There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

## Headline results

27.2% of units have documented, regular meetings with hospital, community and primary care services, with representation of children and families to monitor, review and improve the effectiveness of local unscheduled care services.

**Figure 25: Units that hold regular and documented meetings attended by senior healthcare professionals together with children and parent/ carer representatives for unscheduled care services.**



\* n = 92; missing or unknown = 21

Discussions from site visits showed us that paediatric services, overall, do in fact hold regular meetings, however they are not frequently attended by all healthcare professionals, particularly from primary care.

Clinical leads had queried the most appropriate method of representing children and families during these meetings. This is recognised as a barrier, but services have been recommended that representation from children and young can be acquired via other modes, such as friends and family tests or other patient feedback surveys, is viable.

*"We can't make positive changes or improve our care unless we find out what young people really think of us, that is why this panel is so vital to us."*

Eirlys Thomas, Lead Nurse for ABMyouth.

## **Practice Example**

### **Morrison Hospital, South Wales**

In 2017, Abertawe Bro Morgannwg University (ABMU) Health Board became the first health organisation in the UK to adopt a children's charter, underpinned by the values laid out in the United Nations' 'Convention on the Rights of the Child'.

The children's charter has provided a structure for Morrison Hospital to meaningfully engage children within service redesign. The Youth Board, 'ABMyouth', hosts regular meetings for children and young people, where projects and priorities are discussed. ABMyouth is made up of 20 young people aged between 14 and 24 from across the South Wales region. The group have developed their own constitution, workplan and logo. Actions from their meetings are regularly fed back to the nurses on the ward, who set action plans to make improvements on the ward. ABMyouth have met with Welsh Health Secretary, Vaughan Gething, to discuss their plans in shaping healthcare design. For specific complex-cases or long-term conditions, children, young people and/or parents and carers will be invited to regular meetings.

Children have been extremely active in developing the children's rights initiative having received appropriate training. ABMyouth have worked closely on the '15 steps challenge', giving a child's opinion of their first steps onto a hospital ward and have encouraged the 'smile campaign' in designing posters and leaflets for waiting rooms. Through this, children have visited GP waiting rooms to talk with other children attending GP surgeries about their rights. This has been particularly valuable to Morrison Hospital, which represents a small segment of children's services in the region, as most children are cared for in primary care and young people have been successful in bridging this gap. Currently, ABMyouth are developing a questionnaire for younger hospital patients and are interviewing patients about their personal experiences.

ABMyouth has recently been rewarded for its success in being named the joint winner in the Health, Social Care and Wellbeing category at the Third Sector Awards Cymru 2017.

Contact detail: Eirlys Thomas, Head of Nursing Neonatal and Children's Services, [eirlys.thomas@wales.nhs.uk](mailto:eirlys.thomas@wales.nhs.uk) and Janette Williams, Paediatric Patient Experience Nurse [janette.williams@wales.nhs.uk](mailto:janette.williams@wales.nhs.uk)

ABMyouth website: [www.abmyouth.wales](http://www.abmyouth.wales)

## RCPCH &Us Together

Together &Us has been written and developed with children, young people and parent/ carers from RCPCH &Us as part of the Young Inspectors programme.

In 2017, a group of 5 young inspectors and 1 parent/ carer, all with experience of health services, were trained in visiting and auditing hospitals relating to Facing the Future: Together for child health. As part of this programme, the group shared their views and top tips for healthcare professionals to think about what matters most to children and young people when they present to hospital with unscheduled care needs.

<b>T</b>	<b>Top tip is on communication.</b> One size does not fit all. The first conversation is probably the most important one and the information we leave with at discharge may need to be in different formats or styles for different children and young people - consider different ages, backgrounds and health experiences. Not all communication has to be verbal!
<b>O</b>	<b>Other languages.</b> We live in a multicultural and ethnically diverse country. Where possible, have information available in different languages to support and increase our understanding of health and medical information.
<b>G</b>	<b>Good environment.</b> Give us information in an environment that is calm and not too noisy, without distraction from other patients so that we really know and understand what is happening and what to do when we get home.
<b>E</b>	<b>Effort.</b> Consider co-production and different ways of engaging children and young people in service design including helping you to create child/ young person friendly discharge information and getting feedback on if your service met our needs.
<b>T</b>	<b>Talk through the advice you give us.</b> Don't just speak to my parent/ carer. We know everyone's time is stretched but just that extra few moments can make all the difference to help understand what is happening to me.
<b>H</b>	<b>Hospital.</b> Can be a very daunting and scary place for children and young people. Help us to feel supported knowing that we will be looked after.
<b>E</b>	<b>Explain</b> what is going to happen when it's time to leave hospital, clinic, what to expect, who to go to if I am worried when I am at home.
<b>R</b>	<b>Relationships.</b> Take time to understand us, not just what hurts but also what matters to us.

Created by RCPCH &Us volunteers as part of the Young Inspectors programme.

Thank you to Adam, Rebeka, Jack, Jummy, Lynn and Molly.

## Conclusion

This report has illustrated where improvements have been made since auditing the acute standards for paediatric services in *Back to Facing the Future*. An increase in consultant presence during self-identified peak hours on both weekdays and weekends, with marked progress in the time it takes for children to be seen by middle grade consultants are reason to celebrate, in addition to excellent results showing 100% of units that have established a consultant of the week rota enabling better continuity of care for children.

However, continued concerns on the pressures on the paediatric workforce and wide variation in how services are meeting standards threatens the sustainability of the healthcare system. Recommendations that have been developed using the audit results have been aligned with the State of Child Health: The Paediatric Workforce report<sup>8</sup> that calls on the Government for a central increase to the number of paediatric trainee places needed to expand the consultant-level workforce across the UK.

The audit of *Together for child health* shows that services in primary and secondary care settings are not always working together to improve the pathways in unscheduled care. We have recommended that service planners work to oversee relationship building between primary healthcare professionals and the child health service to increase overall integration in children's health services.

Our unique perspective gained through the undertaking of site visits across the UK has exposed poor morale amongst paediatricians and child health professionals. What is clear to us, is how hardworking and highly dedicated the child health workforce are in their commitment to deliver the highest quality of care possible to children and their families.

The RCPCH are committed to supporting paediatric services and child health professionals to implement these standards. The established RCPCH Invited Reviews service and expertise harnessed in the RCPCH &Us network are vital resources available for paediatric teams to maintain the rights of children to receive high-quality, safe and sustainable services.

## Project board membership

Project board member	Role
Emily Arkell	RCPCH, Head of Health Policy
Melissa Ashe	RCPCH, Policy Lead
Roisin Begley	Trainee Representative, North-East Central
Simon Clark	RCPCH, Workforce Officer
Carol Ewing	RCPCH, Vice President of Health Policy
Mark Hannigan	RCPCH, Clinical Standards Quality Improvement Manager
Nicola Jay	Paediatricians in Medical Management (PiMM) Committee Representative
Martin McColgan	RCPCH, Workforce Information Manager
Marie Rogers	RCPCH, Workforce Lead
Nigel Mathers	Royal College of General Practitioners (RCGP)
Arun Ramachandran	RCPCH, Welsh Representative
David Shortland	Chair
Melanie Simpson	RCPCH, Research Evaluation Lead
Fiona Smith	Royal College of Nursing (RCN)
Donella Williams	RCPCH, Project Officer

The project board would like to extend thanks to Lisa Cummins, RCPCH Data Analyst and each of the &Us Young Inspectors who were involved in auditing the standards.

# Appendix

## Methodology

The audit was carried out over the summer and autumn of 2017 in two stages. The first stage was a general survey of all the UK's acute paediatric units, asking them questions about the 10 standards from *Standards for acute general paediatric services* and 11 standards from *Together for child health*, and asking them to conduct a retrospective case note analysis on 20 admissions. The second stage of the audit was a series of 'deep-dive' visits to 14 units across England, Northern Ireland, Scotland and Wales. These visits involved a series of structured interviews, typically with the clinical lead, nurse or ward manager, and trainee paediatricians and in some instances included service planners and medical managers. Where possible, the audit benefited from involvement with children and young people as part of the RCPCH &Us Young Inspectors programme.

Units with acute paediatric services were identified using the results of the RCPCH Medical Workforce Census 2015<sup>1</sup>. The audit survey was sent to paediatric clinical directors of the 161 identified services in June 2017 and 121 units submitted survey data, of which 8 duplicates and bogus submissions were removed resulting in 113 surveys. Data from the survey is based on self-reported information on compliance. Evidence to illustrate compliance was not required.

Where appropriate, comparison data has been presented from Back to Facing the Future: an audit of acute paediatric standards in the UK from 2013. Comparison data from the 2013 report does not present data from the same units but can be used as a marker to monitor progress. Data from the survey is self-reported by clinical directors and clinical leads of paediatric units and some free text provided within survey submissions has been interpreted and included within final reporting.

The retrospective case note audit of 20 acute paediatric admissions were received by 60 out of the 161 paediatric services invited to participate in the audit. The team visited 14 units across England, Scotland, Northern Ireland and Wales to conduct interviews between October and December 2017.

For each case note audit, respondents were asked the following:

- Date and time of admission
- Date and time first seen by a paediatrician on the middle grade or consultant rota
- Date and time first seen by a consultant paediatrician (or equivalent)
- Date and time of discharge
- Whether the child was referred for a paediatric opinion or had their case discussed with a clinician with the necessary skills and competencies before discharge

These data were used to calculate compliance with acute standards 2, 3 and 5 and overall compliance was calculated for each unit.

## Appendix 1.1

### Data collection part 1 – Survey and case note audit

#### Questions for audit of *Facing the Future: Standards for acute general paediatric standards (2015)*

##### 1. Which hospital are you answering these questions for?

##### Standard 1

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

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.

##### 2. What do you consider are your typical peak hours of activity?

	Start of peak time	End of peak time
Weekdays		
Weekends		

##### 3. On weekdays, at what times is there a consultant (or equivalent) present?

- **24 hours a day**
- **09:00 – 21:00**
- **09:00 – 17:00**
- **Other (please specify)**
- **Questions / comments**

Note: Original survey did not include question about consultant presence on weekends and this was asked separately in a follow up email.

##### 4. Please use the box below to record any comments you may have regarding Standard 1 and your answers to the questions relating to it.

## Standard 2, 3 & 5 Case Note Review

### Standard 2

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

### Standard 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 of staff is concerned."*

### Standard 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."*

In order to monitor these standards, we require you to assess 20 acute paediatric admissions retrospectively between the time period 01/03/2017 and 31/05/2017.

You will need to record:

- **date and time of admission**
- **date and time first seen by a paediatrician on the middle grade or consultant rota**
- **date and time first seen by a consultant within the paediatric department**

whether each child had their case discussed with a clinician with the necessary skills described in standard 5 prior to discharge.

Please ensure at least half of those cases were admitted outside 9 am to 5 pm. It is important to complete the case note audit using 20 cases to enable us to analyse and compare your results and to provide you with bespoke feedback.

Please download the Excel spreadsheet Facing the Future Audit 2017 (Case Note Review) and save it on your computer, renaming it with your hospital name and Trust / Health Board.

Once you have completed the spreadsheet, please email it to:

[facingthefuture@rcpch.ac.uk](mailto:facingthefuture@rcpch.ac.uk)

## Standard 4

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

### **5. How often is your medical handover led by a paediatric consultant (or equivalent)?**

- **Two or more times a day on weekdays and weekends**
- **Two or more times a day on weekdays but not at weekends**
- **Once a day on weekdays and weekends**
- **Once a day on weekdays but not at weekends**
- **Less than once a day**
- **Less than once a week**
- **Never**
- **Questions / comments**

**6. Please use the box below to record any comments you may have regarding Standard 1 and your answers to the questions relating to it.**

## Standard 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.

**7. Does your rota structure allow every child or young person with an acute medical problem who is referred for a paediatric opinion to be seen by, or have their 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?**

- **Yes**
- **No**

**8. In practice, does every child or young person with an acute medical problem who is referred for a paediatric opinion get seen by, or have their 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?**

- **Yes**
- **No**

**9. Please use the box below to record any comments you may have regarding Standard 5 and your answers to the questions relating to it.**

## Standard 6

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

A paediatric assessment unit is defined as a facility within which children with acute illness, injuries or other urgent referrals (from GPs, Community Nursing teams, Walk-in Centres, NHS Direct, EDs) can be assessed, investigated, observed and treated without recourse to inpatient areas.

**10. Do you have a paediatric assessment unit?**

- Yes
- No

**11. Please use the box below to record any comments you may have regarding Standard 6 and your answers to the questions relating to it.**

**12. Between which hours is your paediatric assessment unit open?**

	Opening Time	Closing time
Hours Open		

**13. Does the paediatric assessment unit have access to a paediatric consultant (or equivalent) opinion throughout all the hours it is open?**

- Yes, in person
- Yes, by telephone
- No

**14. Please use the box below to record any comments you may have regarding Standard 6 and your answers to the questions relating to it.**

## Standard 7

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

The attending consultant system is also known as the 'paediatrician of the week', 'neonatologist of the week' or 'hot week' and can be defined as one in which the consultant

has no other clinical duties that week but is fully available for the management of acute admissions.

**15. Do you have a consultant of the week (or hot week) system in operation?**

- **Yes**
- **No**

**16. From Monday 5th June 2017 to Sunday 11th June 2017, was the consultant of the week system implemented?**

- **Yes, fully**
- **Yes, partially**
- **No**

**17. Please use the box below to record any comments you may have regarding Standard 6 and your answers to the questions relating to it.**

## **Standard 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."*

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, 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.

Useful documents:

Royal College of Paediatrics and Child Health. *RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital.* 2009.

Royal College of Nursing. *Children's and young people's nursing practice in contemporary health care: guidance for nurses and commissioners.* 2014.

**18. Please enter the number of whole (full) time equivalent funded establishment of doctors/ Advanced Nurse Practitioners working on each rota. This would be the number of staff if there was no sickness/ absences, gaps due to statutory leave, or out of programme time. Please include whether or not they are compliant with EWTR on paper and in practice.**

**If any of these rotas do not exist within the trust, please mark them as not applicable.**

	WTE	Compliant on paper	Complaint in practice
Tier 1 general			
Tier 1 general / neonatal			
Tier 2 general			
Tier 2 general / neonatal			
Tier 3 general			
Tier 3 general / neonatal			

## Standard 9

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

This standard does not apply when the presenting problem is not in 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.

**19. Please select the subspecialties where there is a Specialist Paediatrician available to all paediatricians for immediate telephone advice for acute problems. This telephone advice can be available within the trust or through a network.**

- **Gastroenterology, hepatology & nutrition**
- **Endocrinology**
- **Oncology**
- **Respiratory medicine**
- **Intensive care medicine**
- **Nephrology**
- **Paediatric cardiology**
- **Neurology**

**20. Please use the box below to record any comments you may have regarding Standard 9 and your answers to the questions relating to it.**

## **Standard 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 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.

**21. Do all health teams have access to a paediatrician for child protection advice?**

- Yes
- No

**22. Do all those paediatricians have child protection expertise to at least Level 3 of the intercollegiate safeguarding competences?**

- Yes
- No

**23. At what time are those paediatricians available? (tick all that apply)**

- 24 hours a day, 7 days a week
- weekdays 09:00 – 21:00
- weekdays 09:00 – 21:00
- weekends 09:00 – 17:00
- weekends 09:00 – 17:00
- Other

**24. Are those paediatricians available for both advice and assessment (including provision of medical opinions and reports)?**

- Advice only
- Advice and assessment

**25. Are those paediatricians to other non-health agencies?**

- Yes
- No

## Questions for audit of *Facing the Future: Together for child health* (2015)

### Standard 1

GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.

The telephone advice, in the form of a hotline or hot phone or videoconferencing technologies, is for GPs to directly access consultant level general paediatric advice and support where this may prevent an admission to hospital.

**26. Do GPs have access to immediate telephone advice from a consultant paediatrician at your hospital?**

- Yes
- No
- Comments

**27. Is this immediate telephone advice service commissioned?**

- Yes
- No
- Comments

**28. What time of day is the telephone advice service active? (tick all that apply)**

- Weekdays 09:00 – 21:00
- Weekdays 09:00 – 17:00
- Weekends 09:00 – 21:00
- Weekends 09:00 – 17:00
- Other

**29. Please use the box below to record any comments you may have regarding Standard 1 and your answers to the questions relating to it.**

### Standard 2

Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made."

The rapid-access service (or hot clinic) is a consultant-delivered service aimed at providing a quick, senior paediatric opinion for children who are not ill enough to be referred to the emergency department but who cannot wait for a routine outpatient consultation.

The majority of children should be seen within 24 hours, but in some circumstances this may be extended to 72 hours according to clinical judgement and the needs of the child. The GP and the paediatrician must agree on the urgency and contact should be made with the child and their parents or carers to explain this and reassure them.

**30. Do you provide a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made?**

- Yes
- No
- Comments

**31. In practice, are the majority of children seen within 24 hours or 72 hours?**

- 24 hours
- 72 hours

**32. Please use the box below to record any comments you may have regarding Standard 2 and your answers to the questions relating to it.**

### Standard 3

There is a link consultant paediatrician for each local GP practice or group of GP practices.

The link paediatrician is a named consultant paediatrician who acts as a point of contact between the group of GP practices and the general paediatric service. Their role is to coordinate and signpost services and resources to the group of GP practices.

**33. Is there a link consultant paediatrician for each local GP practice or group of GP practices in your local area?**

- Yes
- No
- Comments

**34. Please use the box below to record any comments you may have regarding Standard 3 and your answers to the questions relating to it.**

## Standard 4

Each acute general children’s service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.

**35. Do you provide a minimum of two education and knowledge exchange sessions per year with GPs and other healthcare professionals who work with children with unscheduled care needs?**

- Yes
- No
- Comments

**36. Please use the box below to record any comments you may have regarding Standard 4 and your answers to the questions relating to it.**

## Standard 5

Each acute general children’s service is supported by a community children’s nursing (CCN) service which operates 24 hours a day, seven days a week for advice and support, with visits as required depending on the needs of the children using the service.

The CCN service operates 24 hours a day, seven days a week, for on-call telephone advice and support and, as a minimum, provides visits between 8am and 8pm, seven days a week.

**37. Is there a community children’s nursing service available 24 hours a day, seven days a week, for advice and support that provides visits to children who require them?**

- Yes
- No

**38. Are there any community children's nursing services linked to your service?**

- Yes
- No

**39. Which hours does this service operate?**

• Weekdays	•	•
• Weekends	•	•

- Other (please specify)

**40. Please use the box below to record any comments you may have regarding Standard 5 and your answers to the questions relating to it.**

## Standard 6

- "There is a link community children's nurse for each local GP practice or group of GP practices."
- The link community children's nurse acts as a point of contact, providing coordinating and signposting advice and support to the group of GP practices.
- You may want to get in touch with your link community children's nurse for their input into this answer.

**41. Is there a link community children's nurse for each local GP practice or group of GP practices?**

- Yes
- No

**42. Please use the box below to record any comments you may have regarding Standard 6 and your answers to the questions relating to it.**

## Standard 7

"When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers."

Relevant health professionals may include, depending on the child's age, a health visitor, school nurse or community children's nurse, and may in some circumstances also need to include other professionals, for example, social care for safeguarding concerns.

The child's unique patient identifier number (NHS number in England and Wales, Community Health Index number in Scotland or Health and Care number in Northern Ireland) is used on all clinical correspondence.

**43. Is a discharge summary provided to the GP and other relevant healthcare professionals electronically within 24 hours of discharge from the hospital?**

- Yes
- No

- **Comments**

**44. How do you audit whether the discharge summary is sent within 24 hours?**

**45. Tick all the relevant individuals that are sent the discharge summary.**

- **GP**
- **Community Children's Nurse**
- **Health Visitor**
- **School Nurse**
- **Child/ Young Person**
- **Parent/ Carer**
- **Other**

**46. Please use the box below to record any comments you may have regarding Standard 7 and your answers to the questions relating to it.**

## **Standard 8**

Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.

**47. Is both verbal and written safety netting information given to children and their parents/ carers at discharge, in a form that is accessible and they understand?**

- **Yes**
- **No**
- **Comments**

**48. Please use the box below to record any comments you may have regarding Standard 8 and your answers to the questions relating to it.**

## **Standard 9**

Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.

The shared electronic healthcare record includes, as a minimum:

- **The unique patient identifier number (NHS number in England and Wales, Community Health Index number in Scotland or Health and Care number in Northern Ireland)**

- **Name, address, date of birth**
- **GP's details**
- **Medications (prescription medication, allergies, bad reactions to any medication)**
- **Active diagnoses**
- **Encounters - recent admissions or visits to hospital, emergency department or out-of-hours centres attendances, appointments booked for the future**
- **Any emergency care plans or personal healthcare plans (for example, for children with long-term or complex conditions)**
- **Safeguarding information including whether they are on or have been on a child protection plan, are Looked After or are care leavers and the name of the responsible local authority**

**49. Do healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic health record?**

- **Yes**
- **No**

**50. Please tick all the relevant professionals that can access the child's shared electronic healthcare record.**

- **Paediatrician**
- **GP**
- **ED Nurse**
- **Other**

**51. Please use the box below to record any comments you may have regarding Standard 9 and your answers to the questions relating to it.**

## **Standard 10**

*"Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions."*

Common acute conditions include:

- **Respiratory conditions**

- **Fever**
- **Gastroenteritis**
- **Abdominal pain**
- **Head injury**
- **Seizure**
- **Self-harm**

**52. Please tick the relevant common conditions where care pathways have been developed jointly with primary and community services.**

- **Respiratory conditions**
- **Fever**
- **Gastroenteritis**
- **Abdominal pain**
- **Head injury**
- **Seizure**
- **Self-harm**
- **Please list other conditions that are not listed above**

**53. Please use the box below to record any comments you may have regarding Standard 10 and your answers to the questions relating to it.**

## **Standard 11**

*"There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services."*

As a minimum, the meetings are held twice a year (every six months) and include representatives from the hospital, community services, primary care and representatives of children and their parents/ carers. The meetings might also include commissioners and service planners and, as appropriate, managers, public health, ambulance services, school nurses, health visitors, community pharmacists, representatives from the local safeguarding/ child protection team and allied health professionals. Actions and learning points are disseminated widely.

The meetings focus on quality (safety, effectiveness and patient experience), quality improvement and risk. This will include monitoring responses to and discussing system-level critical incidents and complaints, root cause analysis of sudden unexpected incidents and coroner's cases, auditing care pathways, developing and progressing plans for quality improvement, monitoring service use and standards, monitoring trends in child health

issues, monitoring trends in attendances, admissions and referrals to hospital and reviewing and responding to patient experience measures.

**54. Do you hold regular meetings attended by health professionals from hospital, community and primary care services with children/ young people representation in order to monitor, review and improve the effectiveness of local unscheduled care services?**

- Yes
- No

**55. Please use the box below to record any comments you may have regarding Standard 11 and your answers to the questions relating to it.**

Thank you & Next steps

Thank you for your help in completing these questions. Please remember to return the excel spreadsheet to [facingthefuture@rcpch.ac.uk](mailto:facingthefuture@rcpch.ac.uk)

**56. Please use the following box to provide any additional comments you have about either of the Facing the Future standards.**

**57. We would like to take a more in-depth look into how both sets of standards are being implemented locally, to understand the practicalities of their implementation in addition to any challenges that are being faced across the UK. We are looking to visit a number of sites across the UK in order to undertake this 'deep dive' activity and to collect a series of best practice examples in our final audit reporting. Whilst the information provided to answer this survey will remain confidential, we believe publishing best practice examples where sites are meeting the standards well will help to drive quality and support paediatric services towards making improvements. If you are interested in sharing any examples please provide your email address and telephone number with a brief description of how you are meeting the standard(s) or alternatively contact [facingthefuture@rcpch.ac.uk](mailto:facingthefuture@rcpch.ac.uk) for more information.**

## Appendix 1.2

### Site visit interview questions

#### Interview questions with Clinical Lead / Director

**1. If standard met:**

- a. How have you ensured that you can meet this standard?
- b. For how long have you been able to meet this standard?
- c. Do you have any evidence that meeting the standard is improving quality/ outcomes?
- d. Is your ability to meet this standard sustainable?

**If standard not met:**

- e. Why are you not able to meet this standard?
- f. Do you feel that not meeting this standard affects quality and outcomes?
- g. Have you got any provision in place to work towards meeting this standard?

**2. Were you aware of the Facing the Future standards before starting this audit?**

**3. On a scale of 1 to 5, with 1 being very easy and 5 not at all easy, how easy do you find it to understand the standards?**

- a. If no, which areas do you not find easy to understand?

**4. On a scale of 1 to 5, (1 very easy & 5 not at all easy), how easy do you find it to meet the standards?**

**5. Which standards do you find easy to meet and why?**

**6. Are these standards useful in benchmarking service provision?**

**7. Are commissioners aware of these standards?**

**8. Have you used the standards in discussion with commissioners and managers?**

- a. If yes, have they been useful?

**9. How do you intend to use the feedback from this audit?**

- 10. Have you made any changes to your service structure as a result of Facing the Future standards?**
  - a. If yes, what have these changes been?
- 11. Is there any further advice, guidance or work in this areas that the College could produce that you would be useful to you?**

## Interview questions with Trainee

- 1. How long have you been working at this unit?**
- 2. What stage are you at in your training?**
- 3. Were you aware of the Facing the Future standards before starting this audit?**
- 4. Do you find the standards easy to comprehend?**
- 5. Do feel any additional pressure on your workload as a result of the Facing the Future standards?**
- 6. What are your general thoughts about Facing the Future?**

## Interview questions with GP

- 1. Were you aware of the Facing the Future standards?**
- 2. Do you have access to immediate telephone advice from a consultant paediatrician?**  
**Have you used this service and how has it worked, i.e change in workload**
- 3. Do you receive discharge summaries for unscheduled visits within 24hours of discharge, if not, do you have the provisions to acquire these (i.e. surgery admin team, contact details of dept. that deals with this)**
- 4. Do you receive a minimum of two education and knowledge exchange sessions per year from the acute children's services?**
- 5. Has a pathway been developed and provided by acute children's service for common acute conditions?**
  - a) If so has this helped?

## Interview questions with Community Nursing

1. Were you aware of the Facing the Future standards, if so what do you think of these standards
2. Do you provide a service 24hrs a day, 7 days a week that gives advice and support with visits as required?
3. Do you provide a link community nurse for each local GP practice or group practices?
4. Do you have access to shared care record?

## Appendix 1.3

### Interview questions asked by Young Inspectors

- Questions for children young people or parent / carers
- Have you been in hospital before? Yes / No
- If no - what information would you like to have when you leave?
- What information were you given about your illness or looking after yourself when you went home from hospital?
- Was the information written down or explained to you?
- Did you find it easy to understand?
- What information would have been helpful for you?
- Questions for staff
- What information do you provide to children, young people or parents / carers when they are discharged?
- Is this information written down or verbally given?
- Do you have accessible versions for young children or those who find reading more difficult?

## Inspired by the voices of children and young people, parents and carers across Facing the Future?

RCPCH &Us has a number of different materials and resources that can be used to build your Facing the Future Superheroes by finding out what they think about the standards and how to get them involved locally. These are all free to download at [www.rcpch.ac.uk/and\\_us](http://www.rcpch.ac.uk/and_us) and can be used in lots of different ways to create sessions with children, young people and families in forums, focus groups, individual discussions, activity days or other sessions or meetings you have locally. We have created an example Superhero session plan below to help get you started.

**Standards are...** Use the **“Tell Me”** activity from Recipes for Engagement edition 1 (recipe 4) to find out what the word standards means to your groups. It will mean different things to different people, but it is important that when we explain standards, we do it in a clear way. Their ideas will help you to create messages that work locally.

**Which standards are important to me?** Use the **“Visual Voting”** activity in Recipes for Engagement edition 1 (recipe 8) to find out which standard is the most important to children, young people and their families. You can define what important means when you explain the activity, e.g. the standard that we need to change or improve first, the standard that has the most impact on my care.

**What do we need to do?** Use the **“Plan It”** activity in Recipes for Engagement edition 2 (recipe 3) to get the group to create a plan as to what needs to happen next on the standard chosen in the previous activity. Think about what needs to change, how it could be changed, the ideas or best examples and how to do this with no money, some money or if there was loads of money.

**Making change happen.** Use the **“Rating tool”** in Understanding a Superhero and add in your ideas for change based on your **“Plan It”** results which should focus on the most important standard from the **“Visual Voting”** activity. This will be your way to check actions now, in 3 months and in 6 months to see if things are changing.

For example, **“Visual Voting”** selected standard 8 and improving discharge information. **“Plan It”** said a no cost idea would be to design a discharge personal poster that gets filled in by the patient with the Doctor at discharge so that it is in their handwriting, their words and they understand what it means. Your **“Rating Tool”** tracks whether this has been designed (now), tried in discharge meetings (3 months) and used everywhere (6 months). You use red for no change, amber for things are happening and green for all sorted.

You can use, adapt or create your own activities to help children, young people and families to work with your setting to make Facing the Future standards make a difference locally. For more information please contact [and\\_us@rcpch.ac.uk](mailto:and_us@rcpch.ac.uk).

## Appendix 2.1: Survey Results

### Facing the Future: Standards for acute general paediatric services

#### Standard 1

##### Weekdays:

**Table 2: Number of units who specified that they experienced peak times at some point during the day, evening or night time**

	Day		Evening		Night	
	Yes	No	Yes	No	Yes	No
England (n=84*)	46 (54.8%)	38 (45.2%)	44 (52.4%)	40 (47.6%)	10 (11.9%)	74 (88.1%)
Northern Ireland (n=6)	5 (83.3%)	1 (16.7%)	3 (50.0%)	3 (50.0%)	0 (0.0%)	6 (100.0%)
Scotland (n=6)	5 (83.3%)	1 (16.7%)	1 (16.7%)	5 (83.3%)	2 (33.3%)	4 (66.7%)
Wales (n=7*)	5 (71.4%)	2 (28.6%)	4 (57.1%)	3 (42.9%)	3 (42.9%)	4 (57.1%)
Total (=103*)	61 (59.2%)	42 (40.8%)	52 (46.0%)	51 (49.5%)	15 (14.6%)	88 (85.4%)

\*There were 10 missing data: 9 from England and 1 from Wales

**Table 3: Consultant presence during self-identified peak periods on weekdays**

	Yes, fully	Yes, partially	No	Missing
England (n=93)	39 (46.4%)	41 (48.8%)	4 (4.8%)	<b>9</b>
Northern Ireland (n=6)	1 (16.7%)	5 (83.3%)	0 (0.0%)	<b>0</b>
Scotland (n=6)	0 (0.0%)	6 (100.0%)	0 (0.0%)	<b>0</b>
Wales (n=8)	0 (0.0%)	7 (100.0%)	0 (0.0%)	<b>1</b>
Overall (n=113)	40 (38.8%)*	59 (57.3%)	4 (3.9%)	<b>10</b>

\*See Figure 1

**Table 4: Consultant presence more than or less than 12 hours on weekdays**

	12 or more hours	Less than 12 hours
England (n = 86*)	54 (62.8%)	32 (37.2%)
Northern Ireland (n=6)	1 (16.7%)	5 (83.3%)
Scotland (n= 6)	3 (50.0%)	3 (50.0%)
Wales (n=6*)	2 (33.3%)	4 (66.7%)
Overall (n=104*)	60 (57.7%)	44 (42.3%)

\*There were 9 missing data: 7 from England and 2 from Wales

### Weekends:

**Table 5: Number of units who specified that they experienced peak times at some point during the day, evening or night time**

	Day		Evening		Night	
	Yes	No	Yes	No	Yes	No
England (n=84)	76 (90.5%)	8 (9.5%)	54 (64.3%)	30 (35.7%)	48 (57.1%)	36 (42.9%)
Northern Ireland (n=6)	5 (83.3%)	1 (16.7%)	5 (83.3%)	1 (16.7%)	5 (83.3%)	1 (16.7%)
Scotland (n= 6)	6 (100.0%)	0 (0.0%)	3 (50.0%)	3 (50.0%)	1 (16.7%)	5 (83.3%)
Wales (n=8)	7 (87.5%)	1 (12.5%)	4 (57.1%)	3 (42.9%)	3 (42.9%)	4 (57.1%)
Overall (n=103)	94 (91.3%)	9 (8.7%)	66 (64.1%)	37 (35.9%)	57 (55.3%)	46 (44.7%)

\*There were 10 missing data: 9 from England and 1 from Wales

**Table 6: Consultant presence during self-identified peak periods on weekends**

	Yes, fully	Yes, partially	Missing
England (n=93)	15 (29.4%)	36 (70.6%)	42
Northern Ireland (n=6)	0 (0.0%)	1 (100.0%)	5
Scotland (n=6)	0 (0.0%)	1 (100.0%)	5
Wales (n=8)	1 (33.3%)	2 (66.7%)	5
Overall (n=113)	16 (28.6%)	40 (71.4%)	56

\* Figure 2

Note: The survey did not initially include a question regarding consultant presence during weekends, a further question was sent to all who responded to the survey only 56 hospitals out of 113 replied.

## Standard 4

**Table 7: number of consultant lead handovers every 24 hours**

	Less than 2	2 or more	Missing
England (n=93)	41 (51.9%)	38 (48.1%)	14
Northern Ireland (n=6)	1 (25.0%)	3 (75.0%)	2
Scotland (n=6)	2 (40.0%)	3 (60.0%)	1
Wales (n=8)	2 (28.6%)	5 (71.4%)	1
Total (n=113)	46 (48.4%)*	49 (51.6%)*	18

\*See Figure 5

## Standard 5

**Table 8: Seen by a clinician (in theory)**

	Yes	No	Total
England	81	0	81
	100.0%	0.0%	100.0%
Northern Ireland	4	0	4
	100.0%	0.0%	100.0%
Scotland	5	0	5
	100.0%	0.0%	100.0%
Wales	7	0	7
	100.0%	0.0%	100.0%
Overall	97	0	97
	100.0%	0.0%	100.0%

n 97; missing data 16

**Table 9: Seen by a clinician (in Practice)**

	Yes	No	Total
England	79	2	81
	97.5%	2.5%	100.0%
Northern Ireland	4	0	4
	100.0%	0.0%	100.0%
Scotland	5	0	5
	100.0%	0.0%	100.0%
Wales	7	0	7
	100.0%	0.0%	100.0%
Overall	95	2	97
	97.9%	2.1%	100.0%

n 97; missing data 16

## Standard 6

**Table 8:**

**Table 10: Units with a paediatric assessment unit**

	Yes	No	Missing
England (n=93)	71 (87.7%)	10 (12.3%)	12
Northern Ireland (n=6)	4 (100.0%)	0 (0.0%)	2
Scotland (n=6)	4 (80.0%)	1 (20.0%)	1
Wales (n=8)	6 (85.7%)	1 (14.3%)	1
Total (n=113)	85 (87.6%)	12 (12.4%)	16

**Table 11: Of those units with a PAU, do they have access to the opinion of a consultant paediatrician**

	Yes, in person	Yes, by telephone	Total Yes	No	Missing
England (n=71)	26 (39.4%)	39 (59.1%)	65 (98.5%)	1 (1.5%)	5
Northern Ireland (n=4)	1 (33.3%)	2 (66.7%)	3 (100.0%)	0 (0.0%)	1
Scotland (n=4)	0 (0.0%)	4 (100.0%)	4 (100.0%)	0 (0.0%)	0
Wales (n=6)	3 (50.0%)	3 (50.0%)	6 (100.0%)	0 (0.0%)	0
Total (n=85)	30 (38.0%)	48 (60.8%)	78 (98.7%)*	1 (1.3%)*	6

\*See Figure 7

## Standard 7

**Table 12: units that adopt consultant of the week**

	Yes	No	Missing
England (n=93)	80 (100.0%)	0 (0.0%)	13
Northern Ireland (n=6)	4 (100.0%)	0 (0.0%)	2
Scotland (n=6)	5 (100.0%)	0 (0.0%)	1
Wales (n=8)	7 (100.0%)	0 (0.0%)	1
Total (n=113)	96 (100.0%)*	0 (0.0%*)	17

\*See Figure 8

**Table 13: units that adopted consultant of the week between Monday 5th June 2017 to Sunday 11th June 2017.**

	Yes, fully	Yes, partially	Missing
England (n=93)	76 (95.0%)	4 (5.0%)	13
Northern Ireland (n=4)	4 (100.0%)	0 (0.0%)	2
Scotland (n=5)	5 (100.0%)	0 (0.0%)	1
Wales (n=7)	6 (85.7%)	1 (14.3%)	1
Overall (n=113)	91 (94.8%)	5 (5.2%)	17

## Standard 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

**Note for tables 14-17:** averages for both General and General/neonatal WTE were combined

**Table 14: Average WTE by country and tier**

	Tier 1	Tier 2	Tier 3
England	10.1	9.1	9.6
n	71	69	60
Northern Ireland	7.8	8.0	8.0
n	4	4	3
Scotland	11.8	10.2	9.3
n	5	5	4
Wales	10.7	10.0	7.8
n	7	7	4
Overall	10.2	9.2	9.4
n	87	85	71

**Table 15: Compliance by rota tier and country: Tier 1**

	Less than 10	10 or more	Missing
England (n=93)	41 (44.1%)	30 (32.3%)	22 (23.7%)
Northern Ireland (n=6)	3 (50.0%)	1 (16.7%)	2 (33.3%)
Scotland (n=6)	2 (33.3%)	3 (50.0%)	1 (16.7%)
Wales (n=8)	1 (12.5%)	6 (75.0%)	1 (12.5%)
Total (n=113)	47 (41.6%)	40 (35.4%)	26 (23.0%)

**Table 16: Compliance by rota tier and country: Tier 2**

	Less than 10	10 or more	Missing
England (n=93)	46 (49.5%)	23 (24.7%)	24 (25.8%)
Northern Ireland (n=6)	4 (66.7%)	0 (0.0%)	2 (33.3%)
Scotland (n=6)	2 (33.3%)	3 (50.0%)	1 (16.7%)
Wales (n=8)	3 (37.5%)	4 (50.0%)	1 (12.5%)
Total (n=113)	55 (48.7%)	30 (26.5%)	28 (24.8%)

**Table 17: Compliance by rota tier and country: Tier 3**

	Less than 10	10 or more	Missing
England (n=93)	31 (33.3%)	29 (31.2%)	33 (35.5%)
Northern Ireland (n=6)	3 (50.0%)	3 (50.0%)	0 (0.0%)
Scotland (n=6)	2 (33.3%)	2 (33.3%)	2 (33.3%)
Wales (n=8)	3 (37.5%)	1 (12.5%)	4 (50.0%)
Total (n=113)	39 (34.5%)	32 (28.3%)	42 (37.2%)

## Standard 9

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

**Table 18: specialties available for immediate telephone advice for acute problems for all specialties, and for all paediatricians**

	England (n=93)	Northern Ireland (n=6)	Scotland (n=6)	Wales (n=8)	Overall (n=113)
<b>Gastroenterology, hepatology and nutrition</b>	63 (67.7%)	3 (50.0%)	3 (50.0%)	3 (37.5%)	72 (63.7%)*
<b>Endocrinology</b>	67 (72.0%)	3 (50.0%)	3 (50.0%)	5 (62.5%)	78 (69.0%)*
<b>Oncology</b>	78 (83.9%)	4 (66.7%)	5 (83.3%)	7 (87.5%)	94 (83.2%)*
<b>Respiratory medicine</b>	66 (71.0%)	3 (50.0%)	3 (50.0%)	6 (75.0%)	78 (69.0%)*
<b>Intensive care medicine</b>	77 (82.8%)	3 (50.0%)	5 (83.3%)	7 (87.5%)	92 (81.4%)*
<b>Nephrology</b>	73 (78.5%)	4 (66.7%)	5 (83.3%)	6 (75.0%)	88 (77.9%)*
<b>Paediatric cardiology</b>	74 (79.6%)	4 (66.7%)	5 (83.3%)	7 (87.5%)	90 (79.6%)*
<b>Neurology</b>	74 (79.6%)	4 (66.7%)	5 (83.3%)	7 (87.5%)	90 (79.6%)*

\*See Figure 9

## Standard 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.

**Table 19: units that have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies)**

	Yes	No	Missing
England (n=93)	80 (100.0%)	0 (0.0%)	13
Northern Ireland (n=6)	4 (100.0%)	0 (0.0%)	2
Scotland (n=6)	5 (100.0%)	0 (0.0%)	1
Wales (n=8)	6 (100.0%)	0 (0.0%)	2
Total (n=113)	95 (100.0%)	0 (0.0%)	18

**Table 20: Units that have a Child Protection lead with level 3 safeguarding**

	Yes	No	Missing
England (n=93)	80 (100.0%)	0 (0.0%)	13
Northern Ireland (n=6)	2 (50.0%)	2 (50.0%)	2
Scotland (n=6)	5 (100.00%)	0 (0.0%)	1
Wales (n=8)	6 (100.0%)	0 (0.0%)	2
Total (n=113)	93 (97.9%)	2 (2.1%)	18

**Table 21: hours of access to a paediatrician with child protection level 3**

Units were allowed to select more than one option

	CP 24 hours a day, 7 days a week	CP Weekdays 9am - 9pm	CP Weekdays 9am - 5pm	CP Weekends 9am - 9pm	CP Weekends 9am - 5pm	CP other
England (n=80)	75 (93.8%)	0 (0.0%)	4 (5.0%)	0 (0.0%)	0 (0.0%)	1 (1.3%)
Northern Ireland (n=4)	3 (75.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Scotland (n=5)	4 (80.0%)	1 (20.0%)	0 (0.0%)	1 (20.0%)	0 (0.0%)	0 (0.0%)
Wales (n=6)	5 (83.3%)	0 (0.0%)	1 (16.7%)	0 (16.7%)	0 (0.0%)	0 (0.0%)
Total *(n=95)	87 (91.6%)	1 (1.1%)	7 (7.4%)	1 (7.4%)	0 (0.0%)	1 (1.1%)

\* 18 units did not provide data for this question

**Table 22: Child protection lead with safeguarding level 3, available 24 hours**

	Advice and assessment	Advice only	Not specified	Total
England	73	1	1	75
	97.3%	1.3%	1.3%	100.0%
Northern Ireland	3	0	0	3
	100.0%	0.0%	0.0%	100.0%
Scotland	4	0	0	4
	100.0%	0.0%	0.0%	100.0%
Wales	5	0	0	5
	100.0%	0.0%	0.0%	100.0%
Overall	85	1	1	87
	97.7%	1.1%	1.1%	100.0%

**Table 23: Child protection lead available to other agencies**

	Yes	No	Not specified	n
England	62	11	0	73
	84.9%	15.1%	0.0%	100.0%
Northern Ireland	3	0	0	3
	100.0%	0.0%	0.0%	100.0%
Scotland	4	0	0	4
	100.0%	0.0%	0.0%	100.0%
Wales	4	1	0	5
	80.0%	20.0%	0.0%	100.0%
Overall	73	12	0	85
	85.9%	14.1%	0.0%	100.0%

## Facing the Future: Together for child health

### Standard 1

GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician

**Table 24: GPs having access to immediate telephone advice**

	Yes	No	Missing
England (n=93)	69 (88.5%)	9 (11.5%)	15
Northern Ireland (n=6)	2 (50.0%)	2 (50.0%)	2
Scotland (n=6)	4 (80.0%)	1 (20.0%)	1
Wales (n=8)	6 (85.7%)	1 (14.3%)	1
Total (n=113)	81 (86.2)*	13 (13.8%)*	19

\*See Figure 11

**Table 25: Telephone advice service commissioned**

	Yes	No	Missing
England (n=69)	13 (20.3%)	51 (79.7%)	5
Northern Ireland (n=2)	0 (N/A)	0 (N/A)	2
Scotland (n=4)	0 (0.0%)	3 (100.0%)	1
Wales (n=6)	1 (16.7%)	5 (83.3%)	0
Total (n=81)	14 (19.2%)*	59 (80.8%)*	8

\*See Figure 12

**Table 26: Hours of telephone advice operation**

Availability of hotline	N (%)
Weekdays 09:00 – 21:00	24 (29.6%)
Weekdays 09:00 – 17:00	31 (38.3%)
Weekends 09:00 – 21:00	11 (13.6%)
Weekends 09:00 – 17:00	15 (18.5%)
Other	29 (35.8%)

## Standard 2

**Table 27: Percentage of units with a rapid access clinic where children are seen within 24 hours**

	Yes	No	Missing
England (n=93)	19 (25.0%)	57 (75.0%)	17
Northern Ireland (n=6)	0 (0.0%)	3 (100.0%)	3
Scotland (n=6)	4 (80.0%)	1 (20.0%)	1
Wales (n=8)	1 (14.3%)	6 (85.7%)	1
Total (n=113)	24 (26.4%)*	67 (73.6%)*	22

\*Figure 13

## Standard 3

There is a link consultant paediatrician for each local GP practice or group of GP practices.

**Table 28: Linked consultant paediatrician for each local practice or group of practices**

	Yes	No	Missing
England (n=93)	7 (9.0%)	71 (91.0%)	15
Northern Ireland (n=6)	0 (0.0%)	4 (100.0%)	2
Scotland (n=6)	0 (0.0%)	5 (100.0%)	1
Wales (n=8)	0 (0.0%)	7 (100.0%)	1
Total (n=113)	7 (7.4%)*	87 (92.6%)*	19

\*See Figure 14

## Standard 4

Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs

**Table 29: General children's services providing minimum six-monthly education sessions**

	Yes	No	Missing
England (n=93)	40 (53.3%)	35 (46.7%)	18
Northern Ireland (n=6)	0 (0.0%)	4 (100.0%)	2
Scotland (n=6)	1 (20.0%)	4 (80.0%)	1
Wales (n=8)	3 (50.0%)	3 (50.0%)	2
Total (n=113)	44 (48.9%)*	46 (51.1%)*	23

\*See Figure 15

## Standard 5

Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.

**Table 30: CCN service which operates 24 hours 7 days a week**

	Yes	No	Missing
England (n=93)	13 (16.7%)	65 (83.3%)	15
Northern Ireland (n=6)	1 (25.0%)	3 (75.0%)	2
Scotland (n=6)	0 (0.0%)	5 (100.0%)	1
Wales (n=8)	0 (0.0%)	7 (100.0%)	1
Total (n=113)	14 (14.9%)*	80 (85.1%)*	19

\*See Figure 16

**Table 31: community children's nursing teams that are linked to paediatric services**

	Yes	No	Missing
England	64 (95.5%)	3 (4.5%)	26
Northern Ireland	2 (66.7%)	1 (33.3%)	3
Scotland	5 (100.0%)	0 (0.0%)	1
Wales	7 (100.0%)	0 (0.0%)	1
Total (n=113)	78 (95.1%)	4 (4.9%)	31

**Table 32: Number of hours community nursing services are operational - weekday**

	Less than 12 hours	12 or more hours	Missing
England (n=93)	44 (72.1%)	17 (27.9%)	32
Northern Ireland (n=6)	3 (100.0%)	0 (0.0%)	3
Scotland (n=6)	2 (50.0%)	2 (50.0%)	2
Wales (n=8)	5 (100.0%)	0 (0.0%)	3
Total (n=113)	54 (74.0%)*	19 (26.0%)*	40

\*See Figure 17

**Table 33: Number of hours community nursing services are operational - weekend**

	Less than 12 hours	12 or more hours	Missing
England (n=93)	23 (79.3%)	6 (20.7%)	64
Northern Ireland (n=6)	1 (100.0%)	0 (0.0%)	5
Scotland (n=6)	0 (N/A)	0 (N/A)	6
Wales (n=8)	0 (N/A)	0 (N/A)	8
Total (n=113)	24 (80.0%)*	6 (20.0%)*	83

\*See Figure 17

## Standard 6

There is a link community children's nurse for each local GP practice or group of GP practices.

**Table 34: Linked CCN for each local GP or group of practices**

	Yes	No	Missing
England (n=93)	9 (12.2%)	65 (87.8%)	19
Northern Ireland (n=6)	0 (0.0%)	3 (100.0%)	3
Scotland (n=6)	1 (20.0%)	4 (80.0%)	1
Wales (n=8)	0 (0.0%)	7 (100.0%)	1
Total (n=113)	10 (11.2%)*	79 (88.8%)*	24

\*See Figure 18

## Standard 7

When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.

**Table 35: Discharge summaries are sent to GPs & other relevant professional within 24 hours and given to the child and their parents**

	Yes	No	Missing
England (n=93)	61 (77.2%)	18 (22.8%)	14
Northern Ireland (n=6)	2 (50.0%)	2 (50.0%)	2
Scotland (n=6)	4 (80.0%)	1 (20.0%)	1
Wales (n=8)	5 (71.4%)	2 (28.6%)	1
Total (n=113)	72 (75.8%)*	23 (24.2%)*	18

\*See Figure 29

**Table 36: where discharge summaries are sent to**

	GP	Parent/ carer/ CYP	Other health care professional	Community Children's Nurse	Health Visitor	School Nurse	Child / young person	Parent / carer
England (n=61)	61 (100.0%)	54 (88.5%)	30 (49.2%)	22 (36.1%)	26 (42.6%)	18 (29.5%)	6 (9.8%)	54 (88.5%)
Northern Ireland (n=2)	1 (50.0%)	1 (50.0%)	1 (50.0%)	0 (0.0%)	1 (50.0%)	0 (0.0%)	0 (0.0%)	1 (50.0%)
Scotland (n=4)	4 (100.0%)	2 (50.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	2 (50.0%)
Wales (n=5)	5 (100.0%)	2 (40.0%)	2 (40.0%)	2 (40.0%)	1 (20.0%)	1 (20.0%)	1 (20.0%)	2 (40.0%)
Total (n=72)	71 (98.6%)*	59 (81.9%)*	33 (45.8%)*	24 (33.3%)	28 (38.9%)	19 (26.4%)	8 (11.1%)	59 (81.9%)

\*See Figure 20

## Standard 8

Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand

**Table 37: At time of discharge provided with verbal or written safety netting information**

	Yes	No	Missing
England (n=93)	64 (82.1%)	14 (17.9%)	15
Northern Ireland (n=6)	3 (75.0%)	1 (25.0%)	2
Scotland (n=6)	5 (100.0%)	0 (0.0%)	1
Wales (n=8)	7 (100.0%)	0 (0.0%)	1
Total (n=113)	79 (84.0%)*	15 (16.0%)*	19

See Figure 21

## Standard 9

Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.

**Table 38: Healthcare professionals having access to shared electronic healthcare records**

	Yes	No	Missing
England (n=93)	31 (41.3%)	44 (58.7%)	18
Northern Ireland (n=6)	4 (100.0%)	0 (0.0%)	2
Scotland (n=6)	3 (60.0%)	2 (40.0%)	1
Wales (n=8)	3 (42.9%)	4 (57.1%)	1
Total (n=113)	41 (45.1%)*	50 (54.9%)*	22

\*See Figure 22

**Table 39: Those who answered yes; Healthcare professionals that have access to the shared electronic record**

	Paediatrician	GP	ED Nurse
England (n=31)	28 (90.3%)	14 (45.2%)	28 (90.3%)
Northern Ireland (n=4)	4 (100.0%)	4 (100.0%)	4 (100.0%)
Scotland (n=3)	3 (100.0%)	2 (66.7%)	3 (100.0%)
Wales (n=3)	3 (100.0%)	3 (100.0%)	3 (100.0%)
Total (n=41)	38 (92.7%)	23 (56.1%)	38 (92.7%)

**Table 40: Those who answered no; Healthcare professionals that have access to the shared electronic record**

	Paediatrician	GP	ED Nurse
England (n=44)	13 (29.5%)	5 (11.4%)	11 (25.0%)
Northern Ireland (n=2)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Scotland (n=2)	1 (50.0%)	0 (0.0%)	1 (50.0%)
Wales (n=4)	0 (0.0%)	1 (25.0%)	0 (0.0%)
Total (n=50)	14 (28.0%)	6 (12.0%)	12 (24.0%)

## Standard 10

**Table 41: Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions**

	England (n=93)	Northern Ireland (n=6)	Scotland (n=6)	Wales (n=8)	Total (n=113)
Care pathways Respiratory conditions	51 (54.8%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	53 (46.9%)*
Care pathways Fever	45 (48.4%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	47 (41.6%)*
Care pathways Gastroenteritis	46 (49.5%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	48 (42.5%)*
Care pathways Abdominal pain	31 (33.3%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	33 (29.2%)*
Care pathways Head injury	31 (33.3%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	33 (29.2%)*
Care pathways Seizure	17 (18.3%)	0 (0.0%)	1 (16.7%)	1 (12.5%)	19 (16.8%)*
Care pathways Self-harm	21 (22.6%)	0 (0.0%)	0 (0.0%)	1 (12.5%)	22 (19.5%)*
Care pathways other	10 (10.8%)	1 (16.7%)	1 (16.7%)	1 (12.5%)	13 (11.5%)*

\*See Figure 25

**Table 42: Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.**

	Yes	No	Missing
England (n=93)	9 (15.8%)	48 (84.2%)	36
Northern Ireland (n=6)	0 (N/A)	0 (N/A)	6
Scotland (n=6)	0 (0.0%)	1 (100.0%)	5
Wales (n=8)	1 (100.0%)	0 (0.0%)	7
Total (n=113)	10 (16.9%)*	49 (83.1%)*	54

\*See Figure 24

## Standard 11

There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

**Table 43: units that hold regular meetings attended by health professionals from hospital, community and primary care services with children/ young to monitor, review and improve the effectiveness of local unscheduled care services**

	Yes	No	Missing
England (n=93)	20 (26.3%)	56 (73.7%)	17
Northern Ireland (n=6)	0 (0.0%)	4 (100.0%)	2
Scotland (n=6)	2 (40.0%)	3 (60.0%)	1
Wales (n=8)	3 (42.9%)	4 (57.1%)	1
Total (n=113)	25 (27.2%)*	67 (72.8%)*	21

\*See Figure 26

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