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

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

Published October 2025

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

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Joint Royal Colleges Ambulance Liaison Committee
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
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Royal College of Paediatrics and Child Health
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Published October 2025

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

Contents

Glossary

In the context of this document, see below the definition of key terms and phrases that are referenced throughout.

Term	Definition
Absconding	A child or young person (CYP) leaves the Emergency Department (ED) unexpectedly, without the knowledge of clinical staff and in whom there remains a potential risk of harm to themselves or others.
Adolescents	Adolescence is the phase of life between childhood and adulthood, from ages 10 to 18[i]. It is a unique stage of human development and an important period for laying the foundations of good health[1].
Children and Young People (CYP)	CYP in this document are defined as those under the age of 18 years.
Children and young people seeking asylum and refugees (CYPSAR)	Individuals under 18 years of age who have left their country and are seeking protection from persecution and serious human rights violations. They are 'seeking asylum' if they are waiting to receive a decision on their asylum claim. They are 'a refugee' if their claim has been granted.
Clinical decision maker	A doctor, or other registered healthcare professional, with the necessary competencies to perform a full clinical assessment of a patient and make a plan on how to treat them. Nurses with advanced training, such as ENPs and ANPs, are qualified to work as clinical decision makers.
Equitable access	The principle that all CYP should have fair access to healthcare services, regardless of factors such as age, residence, gender or socioeconomic status.
Frequent attender	A frequent attender to ED can be defined through considering both short- and long-term presentations. A CYP with complex needs and/or long-term condition(s) is more likely to attend ED frequently with urgent care needs and will need a different threshold to a previously healthy CYP attending with a cluster of illnesses or injuries. A two-tier approach to escalation is suggested: **Short term**: 3 or more ED attendances with same presentation within 2 weeks: • 1st attendance: seen by doctor/practitioner • 2nd attendance: review by a senior decision maker • 3rd attendance: senior/specialty review and consideration of extended observation and/or admission with input from Paediatric team. *cont.*

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[i] Based on the WHO definition, noting that it has been changed from 19 to 18 for the context of this document.

Term	Definition
Frequent attender cont.	**Long term:** 6 or more ED attendances in a year. If the CYP is safe to discharge, there should be a discussion with ED senior decision maker and schedule for discussion at a high intensity user group or similar. The short-term trigger is there to catch and prevent the possibility of an unappreciated/emergent significant illness or injury, or a minor illness developing more serious secondary complications. The long-term trigger over a calendar year looks more for patterns in presentation from a safeguarding point of view or some other underlying theme, and hitting this threshold should result in a closer review of these attendances.
Integrated Care Board (ICBs)	The statutory organisation within an Integrated Care System responsible for planning, funding and overseeing NHS services in their area. Most of the functions performed by an ICB were previously undertaken by Clinical Commissioning Groups (CCG). ICBs work with partners across the Integrated Care System to allocate resources and commission services.
Lead clinician	The senior clinician at the head of an emergency care team. This position may be held by a consultant or a senior member of nursing staff. They offer clinical and administrative leadership to ED staff within their team.
Primary Care	The first point of contact for most people seeking healthcare in the UK. This encompasses a range of services, including general practice, community pharmacies, dentistry, and optometry.
Senior decision maker	A clinician with sufficient training and experience to make independent decisions about patient treatment and disposition[2]. This may be within a full or limited scope of practice in the context of an Emergency Medicine Service, and does not imply that clinical support /supervision is never required. RCEM Tier 4-5 (and in some cases RCEM Tier 3[ii]) or RCPCH Progress+ training grades ST4-7 (and in some cases RCPCH ST3[3]). Specific tasks performed by senior decision makers, for example safeguarding assessments, may require specific competencies and locally agreed solutions. These are detailed in the relevant sections of the document where appropriate.
Size of units (ED)	For the purpose of this document, paediatric ED sizes are defined as: • Small department: less than 30,000 attendances a year • Medium department: 30,000-60,000 attendances a year • Large department: more than 60,000 attendances a year

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[ii] See https://rcem.ac.uk/wp-content/uploads/2025/08/Tiers2-February-2025.pdf for further information on RCEM Tier equivalents to specialty training grades.

Term	Definition
Service planner	A service planner is responsible for designing, coordinating, and optimising healthcare services to meet population needs. Their role involves assessing demand, allocating resources, and ensuring alignment with national policies and local priorities.
Urgent and emergency care (UEC) services	UEC covers both non-life-threatening illness and injury which require urgent attention, and life-threatening illness or injury requiring immediate intervention. UEC services are usually provided by EDs in hospitals, but also by out-of-hours primary care services, minor injury units, urgent treatment centres, NHS 111, NHS 24 and community pharmacy services. The standards outlined in this document are designed to apply to EDs treating CYP (unless stated otherwise, for example in Chapter 1: An integrated urgent and emergency care system). However, parts of this document may also be applicable to other UEC settings where appropriate.

Foreword

Welcome to the 5th update of the Facing the Future: Standards for children and young people in emergency care document.

A great deal has happened since publication of the previous standards in 2018, including the global COVID-19 pandemic and further health service reorganisation. Whilst this period has seen continuing positive developments in paediatric emergency care in respect of new facilities, continued workforce expansion and improvements in clinical practice, significant challenges remain and there is more that needs to be done.

Children and young people (CYP) have not fared well in the post-COVID recovery of health care services, exacerbating pre-existing underinvestment for this patient group. Insufficient resourcing has placed additional pressure on the paediatric emergency care system, with an emerging gap between system capacity and increasing demand[4].

The Royal College of Paediatrics and Child Health (RCPCH) is working with policy makers to rebalance funding priorities between paediatric and adult emergency care services[5]. The increasing demand for emergency care services from CYP needs to be addressed through both national system-wide, and more local service-level solutions. CYP deserve equitable access to the highest standards of emergency care at a time in life when they are at their most vulnerable.

This document, compiled using the combined experience and expertise of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care, has evolved from previous editions. It is designed to furnish health service planners and paediatric emergency care providers with a set of relevant evidence-based standards to ensure the effective design and delivery of high-quality emergency care for CYP.

Although continuing financial constraints make service development challenging, this standards document aims to support the efforts of hard-working frontline paediatric emergency care staff and strike the right balance between aspiring to the very best, whilst remaining pragmatic and locally deliverable.

Dr Scott Hendry
Consultant in Paediatric Emergency Medicine
Chair of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care

Executive Summary

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

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

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

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

42	All CYP presenting to the ED following self-harm or in mental health crisis, must have a face-to-face developmentally appropriate biopsychosocial assessment of their immediate emotional and mental health needs within one hour of referral [6], undertaken by a mental health professional from a paediatric liaison psychiatry/ mental health crisis team experienced in carrying out such an assessment	**62-69**
43	A clear system is in place with allied agencies to escalate the care of CYP who present with a mental health concern who • require Tier 3(+)/Tier 4 inpatient care, or • who do not require Tier 4 inpatient care but whose parent/carer feels unable to take them home	
44	There is a clear pre-defined pathway for CYP on a section 136 order for an identified place of safety to meet their medical and mental health needs, as outlined in a local place of safety policy	
45	ED staff receive training in how to communicate effectively, assess risk and immediately manage CYP with mental health needs and in supporting their family/ carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity/competence[iii]	
46	ED guidelines are in place for the management of an acutely distressed or agitated CYP incorporating the use of de-escalation strategies, reasonable environmental adjustments and chemical/physical restraint for those who are at risk of harm to themselves or others	
47	When CYP require access to a mental health inpatient bed, but there is a delay of >4 hours, they should be looked after in a suitable paediatric clinical location with appropriate inpatient facilities, regular CAMHS reviews and physically present registered mental health and paediatric nurse support	
Chapter 7: Children and young people with complex needs		
48	There should be systems in place in the ED to identify/ flag CYP with complex needs. ED staff should ask to see the CYP's Emergency Care Plan (ECP), where one exists, which should be held electronically wherever possible to signpost to relevant information, such as the possible requirement for early senior assessment or the need for reasonable adjustments. Systems should be in place to enable CYP with complex needs to be prioritised, following a needs-based approach, when seen in the ED	**70-76**
49	When treating a CYP with complex needs in the ED, systems should be in place to enable escalation for review by a senior decision maker	
50	EDs should have accessible information and communication tools available for CYP with complex needs and/or communication differences including, but not limited to, pain assessment tools, access to an interpreter (including for sign language) and visual aids such as social stories and easy-read information leaflets	

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

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

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

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

Introduction

Aims and scope

The Facing the Future standards for emergency care form part of a suite of standards from the Royal College of Paediatrics and Child Health (RCPCH). Together with the wider facing the future suite, they collectively outline how to deliver a safe and sustainable high quality integrated care service to meet the health needs of children and young people (CYP) in the UK. Being able to access the right care from the right person, in the right place and at the right time is key to this process[7,8]. The standards are designed to provide a dynamic service framework with ongoing audits, updates and regular revisions to reflect new evidence and best practices in health care.

The purpose of the emergency care standards remains unchanged from their first iteration in 1999 - to serve as a contemporary reference point for driving improvements in the quality and provision of emergency care for CYP[9]. The document sets out clear standards of care which are intended to act as a tool and evidence-based resource for healthcare professionals, managers, providers, commissioners and regulators to help plan, deliver and quality-assure paediatric emergency care services[10].

Rights based approach to care

The United Nations Convention on the Rights of the Child (UNCRC) is the most comprehensive statement of children's rights ever produced and the most widely ratified human rights treaty with 196 countries having ratified it by August 2025. These rights reflect children's entitlement to the wider determinants of health including good education, high quality housing and access to healthcare[11]. Article 24 specifically focuses on the right of every child to receive the best health care possible. Article 12 states the right of children to be able to share their views and for these views to be heard[12]. In addition to driving improvements in health care for CYP, another essential component of the Facing the Future project is incorporating the rights of CYP to be involved in decisions about their healthcare.

> *State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.* ***Article 12 of the UNCRC***[12]
>
> *State parties should also introduce measures enabling children to contribute their views and experiences to the planning and programming of services for their health and development. Their views should be sought on all aspects of health provision, including what services are needed, how and where they are best provided, discriminatory barriers to accessing services, quality and attitudes of health professionals, and how to promote children's capacities to take increasing levels of responsibility for their own health and development.* ***General Comment 12 of the UNCRC***[13]

As defined by UNICEF, a rights-based approach translates the theory of the UNCRC into practical actions for service providers, looking at dignity, respect, participation, and development, non-discrimination, transparency and accountability, best interests, interdependence and indivisibility[14]. Adopting a rights-based approach ensures that CYP, along with their parents and carers, remain at the heart of services by actively seeking out and sharing their views to help shape healthcare policy and practice, then working with them to be actively engaged in health service design, delivery, improvement and review[15]. The same principles have been applied in the revision of these emergency care standards, supported by the RCPCH &Us network.

Other resources including the iSupport standards[16] provide internationally recognised, rights-based guidance to ensure that the physical, emotional, and psychological wellbeing of CYP is central to all healthcare procedures. The principles are applicable to these emergency care standards.

RCPCH working together with the Association for Young People's Health (AYPH), CYP, the RCPCH Engagement Committee and a multi-disciplinary Engagement Standards Working Group, have developed a set of standards to support collective engagement with CYP in health settings across the UK. The standards can be used by all NHS healthcare professionals and services, as well as those who plan and commission services. They support the rights of CYP to be listened to, respected, and involved in decisions that affect them, as outlined in the UNCRC[12]. These standards will be available from November 2025[17].

Age

The emergency care standards use the UNCRC definition of a child, which is everyone under the age of 18[12], and have been written to apply to this population of Emergency Department (ED) attenders. It is recognised that the local organisation of emergency care for young people aged 16 and 17 years of age can vary across the UK, and that young people aged 18 and over are sometimes seen in paediatric EDs if their needs are not best met in an adult ED environment.

Setting

These emergency care standards are applicable to EDs seeing CYP. There are a number of other Urgent and Emergency Care (UEC) settings where CYP will present, including Urgent Treatment Centres, Minor Injury and Illness Units, out-of-hours Primary Care, and Same Day Emergency Care and Paediatric Assessment Units. It is beyond the scope of this document to specifically address the individual variations in set up, staffing and practice of these different clinical settings, although the emergency care standards are accessible for other UEC services to adopt or apply as they may deem locally appropriate.

There are a range of different EDs that see CYP. These include large standalone paediatric EDs within specialist children's hospitals, larger mixed EDs seeing adults and CYP in bigger tertiary hospitals, and smaller mixed EDs seeing adults and CYP in a district general hospital setting[18].

Whilst these emergency care standards have been developed to apply across the range of different EDs seeing CYP, it is important to acknowledge that each type of ED will present its own set of challenges. The Intercollegiate Committee recognises that a proportion of the standards listed in the document will be more difficult to meet in smaller EDs. That said, the standards are intended to drive improvements in emergency care for all CYP and encourage all EDs seeing CYP to raise the baseline of their quality of care. EDs should aim to further develop their service around the standards and, as far as possible, deliver parity of experience for all CYP accessing emergency care. Where certain standards might be more difficult to meet, perhaps only partially, or fully but only after an extended period of time, there are indicators within the chapters and practice examples to assist services to gradually evolve towards successfully achieving a particular standard.

Development of the standards

This 5th update of the Facing the Future standards for emergency care has been produced to meet the needs of CYP by those with expertise in paediatric emergency care, including children and parents and carers themselves. It is the end result of a staged revision process agreed by the Intercollegiate Committee and RCPCH, after consultation with a wide range of stakeholders. The committee was supported throughout the process by RCPCH Health Policy staff.

The following stages were undertaken in the development of this document:

Consultation

There was an initial consultation process, involving identification of a comprehensive set of key users and stakeholders, and circulation of an online survey form. The survey sought views on whether the 4th edition of the emergency care standards was meeting their needs and invited suggestions on how the content and structure of the standards might be improved. This multidisciplinary group included NHS health care providers and regulators, UK Nations representatives and a number of royal colleges. RCPCH &Us were involved throughout the revision process. Information from the completed survey forms was collated and significant themes were identified for consideration by the Intercollegiate Committee.

Evidence

In order to accurately inform the future design and provision of emergency care services for CYP, it was essential that the revised set of emergency care standards remained credible, relevant and continued to reflect contemporary developments in this field. It was therefore important that, for certain elements of the existing standards document, the revision process included some form of structured review of the current evidence base.

Rapid reviews are recognised as an acceptable accelerated approach to generating evidence and clinical knowledge. In general terms, the rapid review process follows that of a systematic review process, but with some components of the process being simplified or omitted[19].

Given the nature of the standards document, together with the need to identify any new knowledge and evidence for relevant chapters in a timely and resource efficient manner, the Intercollegiate Committee chose to adopt a rapid review methodology.

The steps in our rapid review process were drawn from guidance and recommendations of the Cochrane Rapid Review Methods Group. The guidance assisted in the identification and appropriate development of research questions, eligibility criteria, searching the literature, study selection, data extraction, quality appraisal and how to draw final conclusions[20].

The committee acknowledged that in many areas of paediatric emergency care practice there is little published evidence in the literature, and that which does exist is often of poor methodological quality. This situation is now changing with the establishment of well organised research networks in paediatric emergency medicine, both in the UK and internationally, who are designing and conducting high quality research studies[21].

Revision process

The Intercollegiate Committee reviewed the former 4th edition of the emergency care standards, informed by the results of the stakeholder scoping survey. Key questions on changes to the structure and content of the document were discussed and addressed. Workload for the revision was divided between committee members, with identification of a lead reviewer for each chapter, together with a supporting committee member to assist. Following establishment of this working group, chapter lead information packs were circulated to ensure a standardisation of approach to the revision process across the whole document. The evidence base for each chapter text and the associated standards were reviewed, and the chapter content subsequently edited and updated.

Working first drafts for each chapter were produced and shared with the committee and key internal RCPCH stakeholders. This produced agreement on a draft emergency care standards document to go out for consultation to the previously identified group of key external users and stakeholders, together with a structured online feedback form.

Feedback from this external consultation process was considered and integrated into the standards document as appropriate. There was a final editing and consensus process involving the chapter leads, the Intercollegiate Committee as a whole and other RCPCH committees and senior college officers, ahead of final publication.

The case for ongoing change

CYP make up a quarter of the UK population and are frequent users of UEC services, with the number of CYP attending UEC settings increasing significantly over the past decade. Despite this increasing demand, focus and investment to improve emergency care services have been primarily targeted on the adult system. This has left the specific needs of paediatric emergency care largely neglected by health service policy makers, creating a growing problem with lack of capacity[4, 5].

In addition to increasing demand, and the funding and capacity concerns, many CYP who attend UEC settings could be seen elsewhere. CYP have the highest rate of unnecessary ED attendance of any age group. Almost 40% of paediatric ED attendances can be classified as ‘non-urgent’, with an even higher proportion among younger children and those children attending out of hours[22]. Such unnecessary ED attendances are less satisfactory for CYP and their families and contribute to ED crowding, which puts more acutely unwell children at risk and makes EDs less resilient to surges in activity.

Numerous health service initiatives, plans and system changes continually alter the community healthcare landscape. The system is trying to ensure that children get the right emergency care, in the right place at the right time. However, problems exist with CYP accessing and navigating a stretched UEC system that does not have sufficient capacity to meet the demand at each stage, with CYP often getting stuck and delayed in the wrong parts of the system[23]. EDs, with a strong ubiquitous health care brand and open 24/7 for any self-presenting patient, are frequently a destination of failure following an unsuccessful encounter with another part of the UEC system.

This fundamental issue with the continual reorganisation of UEC failing to resolve the challenge of increasing demand and insufficient capacity, has been an unfortunate common thread through previous editions of these standards. A genuinely effective solution appears elusive, although this has not been because of a lack of policy initiatives. However, progress is limited by financial constraints and silo working, where pockets of effective practice have emerged, but are not shared[24].

The publication of this edition of the standards is no different, coinciding with a further set of different UEC policy initiatives including the Getting It Right First Time (GIRFT) National Review of Emergency Medicine[25] and the latest NHS 10 Year Health Plan[26] and UEC Recovery Plans[27].

Underlying familiar themes, all of which have featured in previous policy initiatives, include a shift from hospital to community-based care, a focus on closer working between secondary and primary care teams and the development of local and regional clinical paediatric UEC networks.

We need to remain optimistic that, whilst the persistence of these long standing problems is disheartening, with a renewed focus on the right integrated whole system approach, application of the relevant emergency care standards in this document and adequate prioritised funding, paediatric UEC systems will eventually emerge in an effectively organised fashion, with evidence-based pathways successfully meeting the needs of our paediatric patients and their families.

Audit

Following publication, there will be a forthcoming RCPCH audit toolkit, intended to support organisations in adopting and benchmarking themselves against the Emergency Care Standards outlined in this document and with the wider suite of the Facing the Future standards. It will serve as a comprehensive resource to support organisations and EDs in assessing their readiness and compliance following the publication of these updated standards. The audit toolkit will play a crucial role in embedding the standards in everyday practice and ensuring that EDs are better equipped to meet evolving pressures and the needs of their CYP patients.

5th Edition: what has changed?

This latest revision of the Facing the Future: Standards for children and young people in emergency care aims to continue to build on the success of previous editions. The emergency care standards have become an established feature of the paediatric emergency medicine landscape and have evolved in tandem with the significant changes in UEC practice that have taken place over the past 25 years. These standards have helped to set a welcome expectation of high-quality emergency care for CYP and continue to drive new practices and improvements. Please see the ‘5th Edition: What has changed?’ document on the RCPCH website which details the full changes in this 5th Edition.

This edition reiterates those standards that have come to form a well-established baseline of organisational and clinical paediatric emergency care practice, whilst refreshing and updating others. However, this is an updated version of the document and includes new information and standards which are intended to address challenges and concerns that have emerged since publication of the current version in 2018.

The first chapter on an integrated urgent and emergency care system addresses the perpetual challenges with urgent care pathways and the imbalance between demand and capacity and covers new areas including ED crowding, escalation and redirection policies. The chapter on built environment provides greater detail on paediatric ED design and is intended to apply to both new build and refurbishment projects. Chapter 3 on Workforce and training introduces new standards for the number, organisation and training of the paediatric ED medical and nursing workforce and on staff wellbeing. The fourth chapter on management of the sick or injured child brings new information on triage, PEWS in the ED and patient streaming.

Chapter 5 contains important information and guidance on safeguarding and child protection processes in the ED, whilst the chapter on mental health has several new standards, including the importance of a timely mental health professional review and safe onward admission for CYP with a mental health issue. The chapter on CYP with complex needs has been expanded and completely overhauled. Chapter 8 on health improvement and inequalities is new and addresses several topical issues relevant to paediatric emergency care. The following chapters on major incident planning and safe transfers have been updated in line with current best practice. Chapter 11 on the death of a child and young person has undergone extensive revision, highlighting important common principles applying across the UK nations. The final chapters on information systems and research have been refreshed in line with recent developments and priorities in these sectors.

The delivery of high-quality emergency care to CYP is arguably as challenging today as it has ever been. These revised emergency care standards aim to continue to support and inspire hard pressed emergency department staff across the UK to provide the very best possible clinical care, both collectively to the population of CYP they serve, and on an individual basis to the often vulnerable young patient in front of them.

Chapter 1: An integrated urgent and emergency care system

Paediatric Emergency Departments (EDs) function most efficiently and effectively when they form part of an *integrated* urgent and emergency care (UEC) system that enables the delivery of safe, timely and appropriate UEC through a range of tailored services. While the other chapters in this document apply specifically to EDs, this chapter outlines standards for the wider UEC system including settings outside of the ED, that support the delivery of UEC to children and young people (CYP).

CYP should receive coordinated, competent and family-centred care at the right time and in the right place. The ambition to better integrate care is described in the NHS England (NHSE) 10-year health plan[26], and the NHS Long Term Plan[28]. The need for this is ever more apparent following the detrimental impact of the COVID-19 pandemic on the health and wellbeing of CYP in the UK.

The Child Health in Practice Group describe the principles of a well-designed integrated service[29]. Expertise across various settings should be harnessed through whole-system networks and partnerships designed to enhance the capabilities of professionals working in primary care, pharmacies, ambulance services and hospitals, as well as in education and local government. Adopting this approach helps to develop robust models of care[30].

"[We need] holistic support - not only for crisis moments. Local community services at school, proper education and media skills" Young Person, RCPCH& Us 2025

"Local community health centres enable young people to feel reassured they're safe and help sustain relationships with NHS workers. It's also reassuring if you can access health services nearby as it can be quite costly to travel." Young Person, RCPCH& Us 2025

The whole pathway approach to urgent care

A sustainable and resilient UEC system is supported by empowering CYP and their parents and carers to identify the level of care they require. Care pathways should encompass the whole system, including self-management of minor illnesses with the support of online or printed information, community care delivered by GPs, nurses, pharmacists and allied health professionals, and hospital-based care. Clear service information, available in multiple languages tailored to the local population, supports CYP and their parents and carers to access the right care provider within a managed directory of services, which should include a variety of health care, mental health, social care and voluntary sector providers.

Technological innovation can also support the development of integrated care pathways. A 'digital first' approach, with remote contact through a web-based or telephone decision support tool (such as NHS 111, or NHS 24), built on standardised, evidence-based paediatric pathways can inform home management and provide advice on self-care, when safe and appropriate[31]. Clinical advisory services (CAS), provided by clinicians competent in remote assessment, can differentiate patients needing emergency care from those that can be safely managed by other services. For example, Flow Navigation Centres in Scotland provide clinician-led service redirection and virtual ED appointments to help to reduce ED attendances. With consideration of the need for equitable digital access, telehealth has the potential to extend the reach of specialist care by providing an effective alternative to in-person visits[32].

Learning from innovative practice

Children's services have been providing ambulatory care in various forms for well over a decade, and a strong infrastructure now exists in several areas. However, progress is sometimes hindered by the isolated development of services. To address this, innovative care models should be more widely adopted and shared across the four UK nations.

For example, closer working between General Practitioners (GPs) and Consultant Paediatricians as part of local child health GP hubs[33] in England can support GPs to manage paediatric patients safely and effectively in the community, and in turn reduce outpatient referrals and ED attendances. Implementing networked pathways of care, such as child health GP hubs, requires collaborative commissioning and shared funding models. Organisations must work together across traditional boundaries to deliver coordinated care, share resources, and implement joint strategies and care pathways.

The case mix of CYP presenting to EDs continues to change, and services should evolve to understand and respond to the needs of their populations. For example, care must be tailored appropriately[34] for CYP who have a physical or learning disability, are neurodivergent or have a mental health condition. Over the past year in England, there has been an expansion of mental health hubs aimed at improving mental health support for CYP. These hubs benefit CYP by offering early intervention, accessibility, comprehensive support and holistic care to contribute to overall wellbeing[35].

The Neighbourhood Health model described in NHSE guidelines for 2025/26 and the 10-year health plan[26] outlines an approach to how health and social care and local government can collaborate to develop coordinated services to improve population health. For UEC, the approach of aligning community-based services such as urgent treatment centres (UTC), community diagnostic hubs and virtual wards with hospital-based services will enable a truly integrated system which can use local intelligence, such as data on high intensity users, to target interventions, thus reducing pressures on acute services and improving outcomes.

Young people should be seen in settings appropriate to their development and by staff trained in relevant skills including communication, knowledge of legal aspects of confidentiality and the use of adolescent healthcare screening tools. While they may choose to access emergency care services through adult provision, 16- and 17-year-old patients must be afforded the same rights and standards of care as younger children.

Care pathways

On attending an ED, a CYP's clinical wellbeing should be rapidly assessed using validated standardised tools, so that they can be treated or redirected to the most appropriate local service without inappropriate delays. ED streaming and redirection models should include CYP[36], and systems should develop alternatives to the ED, which are described in more detail below, for those CYP not requiring emergency treatment.

Paediatric same day emergency care (SDEC) services aim to optimise paediatric emergency pathways to assess, investigate and diagnose patients on the day of arrival as an alternative to hospital admission[37]. Such pathways can contribute to reducing pressure in EDs[38].

Specialists in Paediatric Emergency Medicine (PEM) and acute paediatric care, supported by critical care and acute transport services where necessary, should continue to provide a hub for clinical advice as required by other services providing UEC to CYP. Clearly defined pathways, such as Getting it right first time (GRIFT)[39] in England and Getting it Right for Every Child[40] (GIRFEC) in Scotland, are also essential to delineate access to sub-specialist paediatric services such as surgery, cardiology and others. Protocols should exist within local ambulance services to ensure critically ill and injured CYP are conveyed to the most appropriate hospital with the right expertise and resources to manage them as demonstrated, for example, by major trauma networks.

Crowding and surge capacity

Over the last ten years, the demand for UEC has continued to rise across the UK[41,42], with the number of CYP attending emergency settings increasing year on year[43]. CYP attendance rates vary seasonally, by day of the week and by time of the day. EDs seeing CYP must be capable of adapting to meet surges in demand and mitigating the increasingly common problem of ED crowding.

Crowding describes a situation where demand exceeds capacity in the ED. It is an internationally recognised problem with a complex set of causes[44]. Crowding has multiple adverse effects, including:

- increased morbidity, including delays in identifying CYP who require more urgent care
- delays in administering time-sensitive treatments, such as antibiotics and analgesia
- increased clinical errors[45]
- increased admissions[46]
- poor-quality experiences for CYP, particularly those who are neurodivergent or have complex healthcare needs, and their families
- increased proportion of CYP who leave before being seen
- increased staff burnout
- impaired system resilience, including readiness to respond to disease surges and pandemics

Responding to crowding

Crowding results when patient input to the ED rises, patient throughput from the ED slows, and/or patient output from the ED (discharge home, to a ward, ambulatory or other community care services) falls. EDs and acute receiving wards should be able to describe and compare their risk level at any time during a 24-hour period. All EDs should have an escalation policy in place that can be quickly activated in response to departmental crowding or surges in demand. Crowding must be recognised as a ‘whole system’ issue that requires a considered range of system-wide and organisational policies to assist with its prevention and management[47,48]. Measures to help prevent and manage ED crowding should include:

Input:

- Established criteria for redirection to alternative care settings. These settings should have provisions in place to assess and initiate treatment for CYP of all ages
- Established co-working practices that enable UTC and ED settings to mutually support each other according to demand

Throughput:

- Adequate numbers of ED medical and nursing staff to cope with at least 80% of predicted maximum demand
- ED rotas and working patterns designed to minimise staff burnout
- Systems in place to allow the flexing of staff between areas at times of high demand
- Consideration of the development of seasonal staffing models
- An allocated patient flow coordinator[49]
- An effective ED and hospital escalation policy
- Systems in place for the initiation of rapid assessment and treatment (RAT) or 'team triage' models, which have some evidence for reducing ED length of stay[50,51]
- Regularly updated and easily accessible clinical guidelines
- Access to point of care testing/rapid turnaround laboratory services for investigations

Output:

- Systems in place to support the timely transfer of children from the ED to an acute admission ward. Admissions should occur within one hour[52] of the patient being clinically ready to proceed[v]
- Effective real time hospital bed management processes
- Continuous flow systems in place that allow EDs under pressure to transfer a patient to a ward, despite perceived non-capacity, acknowledging the relatively greater risk of a patient remaining in a crowded ED
- Access to clinical decision or short stay units, rapid access clinics and hospital at home models of ambulatory care which provide additional options to facilitate safe discharge from the ED

Alternatives to ED

In the UK, EDs function both as a vital buffer for healthcare systems and as security for patients seeking help for physical or mental illness. Although it is important not to restrict access to this safety net, the provision of alternative UEC services is essential to protect ED capacity and avoid ED crowding and its associated negative impacts. Leaders responsible for emergency care should collaborate within local health systems to improve alternative urgent care options. These might include:

- Equitable access to trusted and tailored health information (available in multiple languages appropriate to the local community), such as Healthier Together or Healthier Families resources, to support self-care and care through community pharmacy services, for example, Pharmacy First
- Telemedicine, including a Paediatric CAS, as part of a local directory of services
- UTCs with access to community diagnostic services for CYP, located in areas of high demand. The operational hours of these services should be matched to patient need, with demand informed by local intelligence
- Urgent telephone advice services for GPs from paediatric senior decision makers, enabling CYP and families to be directed to the most appropriate care pathway
- Integrated care pathways between primary and secondary care, including direct referral pathways into SDEC, rapid access clinics and children's virtual ward services
- Shared care pathways for CYP with complex needs and those with long term conditions that provide an alternative to ED attendance or hospital admission where appropriate, including remote monitoring through a virtual ward model

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[v] As defined by NHS England: "A Clinically Ready to Proceed Timestamp is the first date and time that the care professional, authorised to discharge the patient from the Emergency Care Department, makes a clinical decision that the patient no longer requires ongoing care in the Emergency Care Department." This includes decisions to admit the patient, transfer them to another healthcare provider, or discharge the patient from the ED.

- A Child and Adolescent Mental Health Service (CAMHS) crisis line with home treatment response teams accessible 24/7
- Collaboration with children's services and CAMHS to develop responsive processes and pathways for CYP who frequently experience acute mental health or behavioural crises requiring assessment. These might include pathways that provide direct access to a CAMHS Crisis Team, or bespoke plans for individual CYP, aiming to enable appropriate, safe and timely care to be delivered outside the ED setting where possible
- A coordinated communication strategy to promote patient and professional awareness of alternative options to attending ED

EDs must have effective processes in place to correctly identify CYP who can be safely signposted, or redirected, to the most appropriate service[53]. See Chapter 4: Management of the sick or injured child for further information.

Service planners and providers

Networks of local providers in general practice, the community and organisations are best placed to adapt to their own needs, rather than adopting a one-size-fits-all approach. To be truly "whole system" and achieve successful, sustainable change in service design the resourcefulness of communities should not be overlooked. Child health professionals should be proactive in seeking the experiences of CYP and their parents and carers to co-produce services and ensure continued quality assurance. Service planners, funders, commissioners and providers need to support, encourage and enable cross-boundary and cross-organisational working. To be effective, system partners need to respond to clinical and financial challenges and address potential barriers to collaboration, such as information sharing arrangements[54]. Sharing information across the system and between services is a vital component of an integrated UEC system. See Chapter 12: Information system and quality care indicators for further information.

Standards

No.	Standards	Indicators	Evidence
1	UEC services for CYP are planned, commissioned and delivered through clinical networks using an integrated whole pathway approach.	• Documented meetings attended by service planners, funders and providers to plan UEC services across organisational and geographic boundaries • Evidence of quality assurance and service evaluation processes across the UEC network • Evidence of shared care UEC protocols and guidelines for CYP	CQC. 2023. Patient FIRST: Reduced patients in emergency departments. Review of Models of Integrated Care for Children's Services

2	The care of CYP in UEC settings is planned and delivered using the RCPCH Facing the future: Standards for children and young people in emergency care to appropriately meet their needs	• Audit of the use of RCPCH Facing the future: Standards for children and young people in emergency care	N/A
3	Alternative care pathways are provided to ensure the UEC needs of CYP are met at the right time and in the right place to protect ED capacity and reduce the risk of ED crowding	• Implementation of alternative care pathways for CYP, including SDEC and redirection, to improve UEC capacity across local and regional UEC networks	Crowding in the Emergency Department: Challenges and Best Practices for the Care of Children
4	All UEC services review the attendances of CYP separately from adults to allow the informed planning of future service and workforce provision to accurately meet demand	• Evidence of disaggregation of data and separate attendance information for CYP with appropriate planning in response	N/A
5	ED and hospital escalation policies should be in place to respond to surges in patient activity and ED crowding	• Evidence of appropriate planning and measures in place to manage surge capacity and ED crowding	Crowding in the Emergency Department: Challenges and Best Practices for the Care of Children RCEM. 2024. The Management of Emergency Department Crowding

Practice Examples

Practice example 1: North West London Integrated Care System Child Health Hub (CHH)

The CHH model was developed to address inefficiencies in child health service delivery. It aimed to improve the health of CYP through collaboration and engagement of patients, parents, hospital, community, primary and public health professionals.

This model takes a holistic approach, with paediatric consultants and GPs working together to provide care for children in the local area. It enables the transfer of specialist child health knowledge from St Mary's Hospital to the community by facilitating access for GPs in the area through a dedicated phone line and email for quick advice. The model includes regular specialist outreach clinics and multidisciplinary meetings with GP hubs every 4–6 weeks. It also emphasises building strong community relationships and working with local champions to improve child health outcomes[55].

The CHH model has demonstrated significant improvements in health outcomes for children, including better management of chronic conditions and increased vaccination rates. It has shown potential cost savings by reducing unnecessary outpatient visits and hospital admissions, and the diversion of outpatient activity to CHHs has resulted in more efficient use of clinical hours. The implementation of CHHs has contributed to a more integrated and coordinated care system, enhancing overall health system efficiency.

Challenges exist with the model, including the need for substantial initial investment, potential resistance from stakeholders accustomed to traditional care models and the requirement for ongoing training and support for healthcare professionals. However, the CHH model offers a promising approach to improving child health services in North West London. With appropriate funding and stakeholder engagement, scaling the model countrywide could help to bring about broad health system benefits.

More details:

http://www.cc4c.imperial.nhs.uk/
https://www.cc4c.imperial.nhs.uk//-//media//cc4c//documents//nwlicbchhebdvalue-analysis--final-website-jacx-mallender.pdf?rev=2dbe8dc1081e4bfc8d1008871d061c48&hash=33E0DD48CEDDB9FF1C5EC8D9D150E5BE

Practice Example 2: Acute respiratory infection (ARI) hubs

In anticipation of predicted high seasonal peaks in demand, or during periods of disease surge such as epidemics, healthcare systems have developed models of care that temporarily increase out-of-hospital urgent care capacity. ARI hubs[56], implemented in many areas of England during winter 2022/23, are a good example of this. ARI hubs provided same-day care to adults and CYP with respiratory symptoms identified as requiring face-to-face assessment, but who were unlikely to need hospitalisation. These services had high rates of episode of care completion without onward referral, yet data is lacking to demonstrate an impact on ED crowding. Learning from services that implemented ARI hubs provides an opportunity for greater success with proactive planning, including a system-wide benefit impact analysis.

More details:
https://www.england.nhs.uk/long-read/combined-adult-and-paediatric-acute-respiratory-infection-ari-hubs/

Chapter 2: Environment in paediatric emergency care settings

All urgent and emergency care (UEC) settings should ensure that the environment meets the clinical and personal needs of the children and young people (CYP) attending. The healthcare environment should be private, clean and promote a feeling of comfort and safety. It should be designed with a family-centred approach, to accommodate both CYP and their accompanying parents or carers[57].

As a starting point, there are a series of useful recommendations and guidance on the built environment for Emergency Departments (EDs) and CYP, which are set out in NHS Estates and Facilities Health Building Notes (HBN) 15-01[58]: Accident & Emergency Departments: Planning and Design Guidance and HBN 23[59]: Hospital Accommodation for Children and Young People for NHS England. There are similar HBN publications for NHS Scotland[60] and NHS Wales[61].

Whether for a new build project or refurbishment of an existing department, the design goal should be to produce a physical environment that enhances the way that clinical care is delivered; form should follow function. As the workload of an ED cannot be easily controlled or necessarily predicted, departmental space should be planned so it can serve various purposes. A multifunctional and highly flexible emergency care environment enables the physical ED space to adapt as quickly as the clinical ED when faced with varying situations, which would include seasonal pressures, potential major incidents and future pandemics.

Built Environment

The ED must be designed to cope with maximum predicted activity. Detailed planning regarding clinical activity is essential, considering local trends in the number of paediatric attenders. Analysis of arrival by time of the day, day of the week, and month of the year will help delineate potential surge activity and allow consideration of seasonal variation in workload. Any associated local reorganisation of UEC needs to be factored in, as well as patient drift to a new facility, and the potential for families to attend both the old and new facilities, if a new provision is introduced and they run in parallel. Although a paediatric ED often deals with physically smaller patients, it will require the same, if not a larger area than an adult ED seeing a comparable number of patients, as CYP are usually accompanied by parents or carers, siblings or other family members.

The design and configuration of the ED should reflect the planned operational service model and patient flows. Plotting operational processes and generic clinical pathways on schematic flow charts can be useful, looking at mode of patient arrival and how different categories of streamed patients (for example Resuscitation, Majors, Minors, See and Treat) will move through and exit the department.

CYP have the right to be involved in the development of health services[62]. In EDs that are seeing adult and paediatric patients, it is important that the design and layout of the department are such that the needs of both groups of patients are met equitably[5]. When changes are made to the built environment of an ED, CYP and their parents or carers should be invited to contribute their views and opinions on, and experiences of, emergency care, and these should be used to inform and improve the design process.

"4 hours waiting make sure there's lots of entertainment" Young Person, RCPCH& Us 2025
"Create a relaxing space so we can feel calm" Young Person, RCPCH& Us 2025

Requirements for paediatric emergency care settings treating CYP should include the following:

Layout

- Audio-visual and secure physical separation between adult and paediatric patients should be a common requirement across the department, including waiting areas, triage, resuscitation and other clinical spaces. Paediatric areas in the ED should be zoned off, with secure access points to control entry and exit.
- A waiting area large enough to accommodate CYP and their accompanying family members and carers. There should be designated areas for breastfeeding and nappy changing, as well as toilet facilities and space for pushchairs. There should be clear lines of sight to facilitate observation of waiting CYP during busy periods. Infection control issues should also be considered, particularly following the COVID-19 pandemic.
- Direct rapid access to the resuscitation area for CYP arriving by ambulance or via the main patient entrance. A significant proportion of very sick younger patients arrive unheralded by non-ambulance transport and are carried in through the front door. Therefore, it is essential that the ambulance entrance, main patient entrance, triage area and resuscitation room are adjacent.
- Any associated ED Observation Unit should be co-located with the ED and appropriately thought through in terms of size, specific function and clinical pathways.
- In addition to any ED Observation Unit, other key adjacencies requiring straightforward access routes include radiology, high dependency/intensive care facilities, the acute receiving ward and operating theatres.
- Appropriate consideration must be given to the needs of disabled people using or visiting the department.

Clinical Space

- An appropriate private clinical space for the triage of CYP.
- A dedicated children's resuscitation area with the necessary range of age-appropriate equipment (See Chapter 4: Management of the sick or injured child, section full assessment and treatment). If it is not possible to have a specific paediatric resuscitation space, all necessary paediatric resuscitation equipment should be quickly and easily available, or movable into a multipurpose bay. There should be sufficient space to accommodate all members of the healthcare team involved in looking after critically ill or injured children, together with their parents or carers.
- A relatives' room to provide a separate private space for the parents or carers and family members of the most seriously ill and injured children being managed in the resuscitation area. An adjacent appropriately designed body viewing suite will assist in the management of children who have died before they arrive at the ED, or who die in the ED, and allow parents or carers and family members to spend time with their child.
- Sufficient clinical assessment spaces to meet anticipated numbers of paediatric attenders, including at times of peak activity. There should be clear lines of sight to patients for ED staff. Individual cubicles should be uniformly designed, with monitoring capability to allow maximum flexibility of use.
- Provision of clinical space with the necessary specification to allow for the separate safe assessment of highly infectious or immunocompromised patients presenting to the ED.
- Children with complex medical needs must be specifically considered. This should include:
    - an appropriate quieter waiting area for those who find noisy environments distressing, or for neurodivergent CYP who often benefit from specific sensory distraction.

    - wheelchair access to all areas of the ED e.g. Changing Places[63,64] toilets.
    - hearing loop facilities.
    - an ability for hoist transfer.
    - the availability of appropriate weighing and measuring facilities, as highlighted in the BACD's Weigh to Go! initiative[65].
    - See Chapter 7: Children with complex medical needs for further information.

- One or more assessment rooms specifically designed to safely accommodate CYP with significant behavioural disturbance because of a mental health issue which should be safe, secure and ligature risk-free.
- One or more assessment rooms specifically designed to safely accommodate CYP with alcohol/ drug intoxication, which should be safe, secure and ligature risk-free.
- Additional separate procedure room(s) for performing certain clinical procedures such as venepuncture, suturing or foreign body removal in an area set up for this purpose, allowing audio-visual separation from the rest of the department.
- A plaster room with adequate storage for associated equipment.

Facilities

The overall design approach to UEC settings caring for CYP should aspire to excellence and embrace a degree of imagination and innovation that:

- Makes optimum use of natural light.
- Incorporates a welcoming atrium style entrance and reception area.
- Includes a variety of appropriate artwork such as murals/decorative tiles/prints.
- Makes imaginative use of high-quality wall and floor finishes, colours and lighting to create a warm friendly environment.
- Has a variety of appropriate distraction activities 'built in' - play areas/ceiling mounted artwork/ wall mounted entertainment centres/toy storage.
- Overall has a design that is child friendly, but with a balance in age-appropriate decoration.

There should be a pantry area for the preparation and storage of a variety of healthy age and developmentally appropriate food and drink (including provision for those with food allergies), as well as the availability of nappies, wipes and formula milk on request. There should also be a suitable interview room or private area to allow the discussion of confidential matters relating to patient care such as, for example, safeguarding or mental health issues.

Health promotion and safety-netting advice for parents and carers should be prominently displayed in multimedia forms throughout the department using posters, QR codes and screens, with information available in different languages and compliant with Accessible Information Standards[66]. See Chapter 8: Health improvement and health inequalities for further detail.

It is important that ED design works for staff members, as well as for CYP and their families. The nature and intensity of the clinical workload means that ED staff must often remain in the department throughout their period of duty. Hence, comfortable staff facilities of the right size and specification within the department are essential, and the contribution this can make to staff wellbeing and morale should not be underestimated. Facilities should include sufficient staff toilets, separate changing facilities with showers and secure storage. There should be an adequately sized and appropriately furnished staff rest and dining area, with food storage, refrigeration and warming equipment.

Adolescents

Consideration must be given to adolescent age groups in the design approach and there should be clear arrangements to accommodate young people for whom neither the children's, nor adult areas may be appropriate[67]. This should include a separate waiting area and consulting area, away from younger patients where possible. Adolescents usually prefer quieter, more private surroundings with access to age-appropriate games/entertainment, free Wi-Fi and device charging points.

Standards

No.	Standards	Indicators	Evidence
6	UEC settings are designed to accommodate the needs of CYP, and those of their parents/carers and families. The design approach should aspire to excellence and facilitate best clinical practice with specific provision for adolescents, CYP with complex needs, mental health conditions and/or who are neurodivergent. The design process should be shaped in collaboration with CYP and their parents/carers.	• Evidence of compliance with appropriate governmental Health Building Notes . • Provision of appropriate waiting, clinical and ancillary spaces/ facilities for CYP and their families. • Evidence of involvement of CYP and their parents/carers in service design and delivery • Provision of appropriate staff facilities within the ED.	Appropriate Health Building Notes
7	The design and configuration of UEC settings should reflect planned operational service and patient flow models, with sufficient capacity to cope with anticipated numbers of CYP attenders and additional flexibility to manage surges in patient activity.	• Evidence of the use patient flow models when planning capacity and layout of the built environment.	Appropriate Health Building Notes
8	In EDs seeing adult and paediatric patients, it is essential that the design and layout of the department are such that the needs of both groups of patients are equitably served.	• Evidence of differentiated layout in ED design for adult and paediatric patients. • Collection mechanisms for patient satisfaction data in place, with results showing low disparity between adult and paediatric group.	RCPCH Blueprint

Practice examples

Practice example 1: Wythenshawe Hospital Manchester - Designing a children's ED

Wythenshawe Hospital, part of Manchester University NHS Foundation Trust, recently expanded its ED to include a dedicated area for CYP. Paediatric patients were previously treated in the minor injuries area of the ED. The design of the new children's ED provides a better organised, more welcoming and less stressful environment, including child-friendly decor, play areas to reduce anxiety, and spaces that ensure privacy and comfort during treatment.

The new paediatric area includes:

- A purpose-built space with one triage cubicle and eight Majors/Minors cubicles.
- An audio and visually separate resuscitation room.
- A treatment area designed specifically for patients aged 0-16 years.
- A separate waiting area with a play area for children.

These adjustments help to enhance the efficiency and effectiveness of emergency care for CYP, ensuring timely and appropriate treatment, and that the ED is better equipped to provide high-quality, compassionate care in a supportive environment, focusing on the unique needs of its younger patients.

More details:
https://mft.nhs.uk/2019/02/13/new-childrens-ed-for-wythenshawe-hospital/

Practice example 2: Royal Hospital for Children Glasgow: Sensory room development in the ED

The ED at the Royal Hospital for Children in Glasgow sees approximately 75,000 attenders annually. Like many paediatric emergency settings, the waiting and clinical assessment areas are often busy, noisy, and overstimulating - a particular challenge for CYP with complex or additional support needs (ASN), including those with autism spectrum disorder (ASD). These CYP often experience sensory processing difficulties, and the unpredictable environment of an ED can provoke significant distress, leading to challenging behaviours, difficulty assessing clinical needs and increased anxiety for both the CYP and their family.

Recognising this issue, a short-life working group was formed to improve inclusivity for children with complex needs or ASN in the ED. This multidisciplinary team included play specialists, senior nurses, and emergency clinicians. A parent and staff survey was conducted to gather insights on the current ED environment. Results showed that 60% of parents and 88% of staff felt the ED was not autism friendly. Loud noises and bright lights were identified by 70% of respondents as the most challenging sensory elements, and a recurring theme in free-text responses was the need for a quiet, calming space.

Following this feedback, a successful application was submitted to the Glasgow Children's Hospital Charity to fund the co-design and installation of a purpose-built space within the ED. The room was created in collaboration with a specialist design company to ensure it met the diverse needs of CYP with sensory processing difficulties. Features include low lighting, tactile surfaces, interactive wall panels, soft furnishings, and noise insulation - all designed to create a calming, non-clinical environment.

The sensory room aims to support not only CYP with complex needs and ASN, but any child who may benefit from a quieter, more controlled space during their ED visit - including siblings and CYP with anxiety, neurodivergence, or trauma-related needs. With 37% of Scottish school-aged children identified as having ASN, this space has the potential to benefit a significant number of children annually in the department.

This project represents a meaningful step toward inclusive emergency care, aligning with RCPCH/RCEM standards by promoting equitable access, improving the care environment and responding directly to the voices of patients, families, and frontline staff.

More details:

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Further Useful Resources

- Huddy and Mitchell. 2017. Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition. Available at: https://www.annemergmed.com/article/S0196-0644(16)31327-0/fulltext
- Standards for Emergency Department Design and Specification for Ireland: Irish Association for Emergency Medicine 2024. Available at: IAEM-ED-Infrastructure-Standards-Guidelines-2024-V1.2.pdf
- International Health Facility Guidelines 2025: Part B Health Facility Briefing and Design: 75: Emergency Units Available at: iHFG_part_b_emergency_unit.pdf

Chapter 3: Workforce and training

Paediatric emergency medicine

Paediatric emergency medicine (PEM) is a subspecialty with recognised training pathways to consultant level through both the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Emergency Medicine (RCEM). There are significant benefits to a dual-college approach, as doctors trained through each route have complementary skills and strengths. These training pathways, along with the existence of the Association of Paediatric Emergency Medicine (APEM), have resulted in enhanced paediatric emergency care throughout the UK & Ireland[68].

While Emergency Medicine (EM) and paediatric consultants are highly capable in the care of acutely unwell and injured children, PEM consultants bring additional, specialised expertise that further enhances the quality of paediatric care in EDs. PEM consultants are specialists in undifferentiated paediatric patients with expertise in paediatric medical, mental health, safeguarding, surgical and trauma presentations. Beyond clinical interactions, they are also skilled in patient flow, team working, leadership, communication, and working collaboratively with primary care and inpatient teams. There are many additional benefits of having PEM consultants working in Emergency Departments (EDs), whether through enhancing workforce PEM skills and knowledge, or in other areas, such as reducing hospital admissions. Employing consultants from both the RCPCH and RCEM training pathways in PEM benefits EDs by bringing together their broad range of well-matched skills and clinical experience.

There has been a rapid and sustained growth in PEM consultant numbers in recent years. However, PEM consultants are not evenly distributed across the UK. A 2023 review of General Medical Council data for England, Scotland and Wales found that North East and South West England had more than five PEM consultants per 100,000 children and young people (CYP), whereas the East of England had less than two PEM consultants per 100,000 CYP[69]. Variation in PEM consultant numbers must be reduced to enable the equitable delivery of high-quality paediatric emergency care throughout all the UK nations, between smaller and larger departments and across rural and urban areas.

Paediatric emergency nursing

Nursing staff, including Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) are integral to the delivery of urgent and emergency care (UEC) to CYP. Like doctors, nurses working in paediatric emergency settings come from both paediatric and emergency medicine backgrounds.

All nurses working in a separate dedicated PED must be registered children's nurses. In a mixed adult and children's ED, all registered nurses caring for CYP must, as a minimum, attain and maintain the knowledge, skills and competencies outlined in the RCN National Curriculum and Competence Framework for Emergency Nursing (levels 1 and 2)[70,71]. This includes knowledge and skills related to:

- Effective communication with CYP and their parents
- Safeguarding CYP to Level 3 as defined by the intercollegiate framework[72]
- Pain assessment and management
- Recognition of the sick child[73]

Allied health professionals and non-clinical personnel

A multidisciplinary team (MDT) is crucial for delivering integrated healthcare to CYP and developing well-rounded and versatile emergency care services[74]. Each member contributes their expertise, collaborating to review the CYP's condition and plan ongoing management. The MDT may include mental health workers, play specialists, health visitors, social workers, safeguarding teams, physiotherapists, radiographers and clerical staff, among others. Many EDs are also supported by youth workers, although these are often funded by charities, leading to unequal distribution across services.

Access to play services

Play is a universal right for all CYP[75] and is especially valuable when CYP are unwell. Every ED caring for CYP must have access to a play specialist service[76]. In smaller departments, play services may be shared with inpatient areas, but for larger EDs a dedicated play specialist should be employed by the department, with availability covering hours of peak demand, including evenings and weekends.[77] Provision must be made for CYP with complex needs, learning disability and neurodivergent conditions to support the inclusion of every child. See Chapter 7: Children and young people with complex needs for further information.

The role of a play specialist in the ED includes:

- Working with nursing and medical staff to involve play in the management of CYP during their time in ED.
- Providing distraction therapy during potentially distressing procedures.
- Helping to contribute to a child-friendly environment and advising on safe and appropriate toys, activities and facilities for CYP of all ages.
- Supervision of play for all CYP in the department.
- Advising on requirements for CYP with complex needs, learning disability and neurodivergent conditions.

Youth workers embedded within the MDT

The youth worker's role is to build positive relationships with young people and provide opportunities to help them develop their social, emotional & personal skills through informal education, peer support activities, advocacy, signposting and much more[78]. In healthcare, they aim to increase young peoples' confidence in managing their health, help provide holistic care, and advocate for young peoples' voices, ideas and wishes to be heard when improving or making changes to service design and delivery. Embedding youth workers within the ED team facilitates a public health approach to address complex issues including violence, substance abuse, and mental health concerns[79]. In some services this will be with young people age 11 upwards or may extend to work with children who are under 11.

Youth services have been piloted in MTCs and within EDs to combat knife and violent crime, particularly in large urban centres, including London[80]. For further detail, please see the practice example from King's College Hospital, which has embedded youth workers within its ED for many years.

Clinical staffing

Staffing levels at any time in an ED should be linked to predictable numbers of presentations and likely patient surges. The Emergency Care Improvement Support Team (ECIST) tool can be used to help departments map demand and staffing.

Doctors and nurse practitioners

All EDs treating CYP should employ at least one PEM-trained consultant, with larger centres (see Glossary for definition) having a minimum of one Whole Time Equivalent (WTE) PEM consultant per 3600-4000 new patient ED attendances per annum[81]. Consultants working in a PEM role should fulfil all the requirements of the RCPCH/RCEM training curricula and capabilities for PEM subspecialty training. The current number of consultants and postgraduate doctors in training (PGDiT) in PEM is insufficient to meet this standard. Even with this number, alternative arrangements will still be needed to achieve 24/7 cover for most departments.

As per RCEM standards, consultants should not be expected to work at a greater frequency than 1 in 8 weekends if only one consultant is on duty each weekend day, and 1 in 6 weekends if there are 2 or more consultants on duty each weekend day. Specialist, associate specialist and specialty (SAS) doctors are an invaluable part of the workforce. SAS doctors form a broad group, from doctors new to the NHS through to senior doctors who are able to practice autonomously, albeit with a consultant taking overall clinical responsibility. There is variability within this group around contractual frameworks. The current SAS contracts cover specialist, associate specialist and specialty doctors. There are also doctors employed on non-standard, non-national contracts, often referred to as locally employed doctors (LEDs) although terminology within organisations can vary. It is important that the latter group are treated fairly and that their contracts mirror those of their colleagues practising at the same level.

PGDiT must have a work schedule which is compliant with the Working Time Regulations 1998 and have adequate time for training, as stated in the Reference Guide for Postgraduate Foundation and Specialty Training in the UK ("the Gold Guide") [82]. LEDs should have a locally defined job or work plan designed in accordance with the same principles. Rota design for all doctors should be in keeping with principles of sustainable working.

Constructing a workforce to meet demand and ensure the availability of the correct blend of skills is a complex undertaking, and in many EDs, the workforce is shared across all patient groups. However, it is important that the requirements of paediatric patients in the ED are afforded equal status when considering workforce make-up, and how the workforce is allocated across the department floor.

Recruitment and retention of ED doctors and nursing staff will be profoundly affected by the attention paid to sustainable working practices, whether considering culture, working patterns or working conditions.

Nurses

Nurse staffing levels and skill mix are equally crucial to the effective emergency care of CYP. These must also be at an appropriate level to cope with predictable numbers of presentations and react to likely surges in attendance, or the unpredictable arrival of a critically ill or injured CYP in the department.

When assessing the nursing numbers required on shift, safer nursing tools should be used to set numbers and skill mix, but they should separate CYP and adult ED requirements. EDs treating CYP must be staffed with a minimum of two registered children's nurses (with at least one with an advanced paediatric life support qualification) on shift[83]. For larger units, this should be filled by a Band 6 or above.

A minimum of two registered children's nurses per shift in a separate dedicated PED must possess recognisable post-registration paediatric trauma and emergency training. This will bring added strength to the ED, as an appropriate nursing skill mix is essential to raising the standard of paediatric emergency care.

The Royal College of Nursing (RCN) and RCEM Nursing Workforce Standards for Type 1 EDs[84] address wider aspects such as minimum uplift to cover planned and unplanned leave, practice educators and education and training requirements.

Training and development of clinical staff

EDs must have the workforce capacity, resources and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experience for all clinical staff (as required by their training curricula), and to provide appropriate educational supervision and support.

There should be regular collaborative learning events across PEM networks to nurture working relationships, address operational and governance issues, share case-based learning and ensure a consistent standard of clinical knowledge and skills across the system. Community teams require robust links with specialist PEM and acute paediatric teams. Urgent treatment centres (UTCs) need to link with their local paediatric ED for learning, training and safety netting. Consultants who are trained in PEM are well placed to lead on such collaborative working. Training events should be available to staff from ED, UTC and primary care settings who see acutely ill or injured CYP. The increasing presence of Same Day Emergency Care (SDEC) facilities should lead to an enhanced delivery of UEC and not deplete ED workforce resources.

Consultants

In order to focus on PEM clinical and non-clinical duties, PEM consultants should have an absolute minimum of two Programmed Activities (PAs) of Direct Clinical Care (DCC) in PEM in their job plan. In training departments, this should be significantly more to fulfil the requirement that a minimum of 70% of a PEM trainee's clinical time (excluding night hours) is under close consultant supervision. Administrative duties should be recognised as DCC, and any job plan should accurately reflect the predictable and unpredictable nature of PEM out-of-hours and on-call work. Values for these will vary depending on the size of department and number of consultants in post.

In addition to PEM clinical sessions, other job-planned daytime consultant DCC could include departmental sedation lists, rapid review clinics and the provision of advice lines for GPs and other community services. Other DCC may be in general paediatrics, emergency medicine, paediatric intensive care and/or retrieval medicine or safeguarding, depending on the individual needs of the department and wider organisation.

PEM consultants must also have adequate PAs allocated in their job plan in which to continue their own professional development, develop their service and department and provide Educational Supervision to resident doctors. Model contracts for England, Northern Ireland and Scotland recommend that a full-time working week should be made up of 7.5 PAs allocated for DCC and 2.5 PAs allocated for this Supporting Professional Activity (SPA)[85]. The model contract for Wales recommends allocating 3 PAs for SPA[85]. SPA sessions should also include time for attendance at collaborative PEM network events and work related to governance, research, clinical effectiveness and quality improvement.

SAS doctors

SAS doctors have varying professional development needs. Job plans should comply with contractual frameworks and, as an important general principle, SAS doctors should be treated fairly in comparison with their colleagues within the department. The different individual experience and capabilities of each SAS doctor should be acknowledged. Those who are not practising autonomously should have an educational supervisor. All should undergo annual appraisal. SPA time should be allocated both for personal professional development and to enable clinicians to contribute to departmental leadership and management at a level commensurate with their capabilities. Many doctors will be following a portfolio pathway, with a view to joining the specialist register. This requires skilled supervision. Recruitment and retention of SAS doctors will be affected by the departmental culture around professional development and progression. This group may also contribute significantly to the professional development of other clinical staff within the department.

Doctors in subspecialty PEM training

There will need to be an uplift in the number of doctors training in PEM to achieve the consultant staffing levels required to deliver safe and effective paediatric emergency care equitably across the UK and ensure workforce education and training needs are met. The number of postgraduate doctors in subspecialty PEM training posts has remained relatively static over the last five years, with a gradual expansion in the number of training sites. At the time of publication, there are approximately 200 doctors in subspecialty PEM training across the UK shared between the RCPCH and RCEM. Training centres are subject to a quality assurance programme to ensure that the standard of PEM training is of a high calibre.

Subspecialty training in PEM should be rewarding for both the trainee and the department. EDs delivering this PEM training must do so at the standards stipulated by the RCPCH[86, 87] and RCEM[88] training committees. The training should cover the clinical and non-clinical domains of the joint RCPCH/RCEM sub-speciality PEM syllabus[89], and should enable postgraduate doctors to fully appreciate the role of a PEM consultant by the end of their training. Training programmes should be dynamic, with protected time for consultants to deliver teaching and workplace-based assessments. There should similarly be protected time for PGDiT to learn in line with service delivery. They should be given the opportunity to develop, deliver and implement projects, including quality improvement initiatives with the support of consultants and, where possible, teaching and project delivery should be done at a network level.

Under equality legislation, employers have a duty to make reasonable adjustments to support disabled staff and avoid discrimination. The RCPCH offers resources to support the implementation of reasonable adjustments to ensure training programmes are in line with legislative requirements and best practice. Each trainee should be offered personalised support through a process of determining any reasonable adjustments they may require to help them meet the curriculum and assessment requirements[90].

Specialist clinical practitioners

Training for ENP, ANP and other ACP roles can be variable and is often not specific for paediatrics, despite many of these professionals working solely within paediatric departments. A recognised training programme should be followed; examples include the RCEM EM-ACP Credential (which includes the RCEM Emergency medicine advanced clinical practitioner curriculum[91]) and the RCPCH Paediatric and child health advanced practice area specific capability and curriculum framework

(PCHCF)[92], as well as many other university-affiliated local training programmes. At the time of publication, the Nursing and Midwifery Council (NMC) is undertaking a comprehensive review of advanced nursing and midwifery practice, including consideration of whether additional regulation is needed[93]. Any training and attainment of knowledge, skills and competencies, whether acquired with a professional body such as the RCN, RCPCH or RCEM or via a local framework, will need to be delivered and assessed according to NMC guidance, given its statutory role as a regulator.

Once practitioners are out of formal training, their professional development needs will vary. It is important that departmental education and governance programmes include this group and meet their needs. Recruitment and retention of specialist nurse practitioners will be affected by the departmental culture around professional development and progression. This group can also contribute significantly to the professional development of other clinical staff within the department.

Nurses

It is recognised that recruiting nurses with appropriate skills is increasingly challenging. Developing a flexible nursing workforce with both paediatric and adult UEC skills, for example with appropriate rotational training, is key, especially in smaller units. Creating attractive career development opportunities is also essential for the retention of nursing staff. EDs should encourage professional development and the acquisition of leadership skills in emergency nursing, which could include progression into ENP or ANP training, education, or research. ENPs and ANPs with paediatric and UEC skills increasingly form a vital part of the workforce.

Wellbeing

The importance of staff wellbeing is rightly gaining increasing recognition. ED staff often work unsocial shift patterns in a high-pressure environment and are not always able to deliver the quality of care they aspire to, usually due to external factors beyond their control. This can put ED staff at risk of burn out and moral injury[94]. The Thrive Paediatrics team at RCPCH have developed a roadmap[95] for transforming the working lives of paediatricians, stating: “Every paediatric clinician deserves to work in an environment that actively promotes, supports and enables their wellbeing with a positive, constructive culture”. This should be put into practice within UEC settings. Every ED should have a lead for wellbeing, with appropriate time allocated for this.

RCEM has provided guidance on sustainable working for all professional groups, including how to approach those who are getting towards the latter stages of their career[96]. Whilst it is recognised that not everyone would want a change in their working pattern, the intense nature of ED clinical work and the challenges of late, overnight, and on-call working may need to be addressed for some senior consultants as they approach retirement age.

“Don’t want to see staff running around and panicking” Young Person, RCPCH& Us 2025

“Need less stressed staff” Young Person, RCPCH& Us 2025

Standards

No.	Standards	Indicators	Evidence
9	All EDs treating CYP must include PEM consultants within their consultant workforce with dedicated clinical and non-clinical time allocated to paediatric emergency care	• One WTE PEM consultant per 3600-4000 new CYP presentations per annum in larger centres • Consultants working in a PEM role should fulfil all the requirements of the RCPCH/RCEM training curricula and capabilities for subspecialty PEM training • PEM consultants should have a minimum of two DCC sessions per week in PEM • EDs seeing CYP must ensure a minimum of one PA of consultant (or equivalent) time for PEM specific service development and one PA for PEM related governance activity respectively • There should be a PEM consultant physically present for 70% of a subspecialty PEM trainee's shop floor time within the department, excluding night shifts • As per RCEM standards, consultants should not be expected to work at a greater frequency than 1 in 8 weekends if only one consultant is on duty each weekend day, and 1 in 6 weekends if there are two or more consultants on duty each weekend day[97]	RCEM Workforce Recommendations 2018 RCPCH/ RCEM Paediatric Emergency Medicine Sub-Speciality Syllabus BMA Overview of job planning RCEM Guidelines for the Provision of Emergency Medical Service
10	All EDs treating CYP must have at least two registered children's nurses on each shift, and at least one nurse with an advanced paediatric life support qualification. For larger units this role should be filled by a Band 6 (or above) registered children's nurse	• Evidence of at least two registered children's nurses on shift • All nurses working in a separate dedicated paediatric ED must be registered children's nurses • Evidence of at least one of these having APLS, or equivalent • In mixed EDs seeing adults and CYP, evidence of paediatric competence for adult nurses as outlined in the RCN National Curriculum and Competence Framework for Emergency Nursing (levels 1 and 2) • Use of safer nursing tools to establish adequate numbers and skill mix of staff on shift	RCN. Maximising Nursing Skills in Caring for Children and Young People in Emergency Settings RCN. National Curriculum and Competency Framework for Emergency Nursing Level 1 RCN. National Curriculum and Competency Framework for Emergency Nursing Level 2

No.	Standards	Indicators	Evidence
11	All EDs treating CYP must always have clinical staff on duty with the necessary paediatric competencies for the safe immediate assessment and management of critically ill and injured CYP	- At least one APLS (or equivalent) qualified senior clinician on duty at all times - All senior decision makers have APLS or equivalent - At least one senior registered children's nurse (Band 6 and above for larger units) with APLS or equivalent on duty on each shift - All senior registered children's nurses (Band 6 and above) have APLS or equivalent - All Band 5 registered children's nurses have PILS (Paediatric Immediate Life Support) training or equivalent. Further training in neonatal emergencies and trauma management is desirable	RCN. Maximising Nursing Skills in Caring for Children and Young People in Emergency Settings
12	All EDs treating CYP should have dedicated education, training and governance sessions focused on the care of CYP for all ED staff. In mixed departments, this could form part of an integrated education programme	- Evidence of a structured education programme - Number of professional development training hours offered each year	BMA Overview of job planning
13	All EDs treating CYP should actively support the professional development, acquisition of leadership skills and career progression of their paediatric emergency nursing workforce	- Evidence of a culture that promotes high quality patient care and supports the recruitment and retention of emergency nurses - Evidence of participation in departmental education, training, and governance activities - Encourage progression to AP training via RCEM, RCPCH, or locally agreed credentialing course	RCEM Emergency Medicine Advanced Clinical Practitioner Curriculum RCPCH Paediatric and child health advanced practice area specific capability and curriculum framework
14	All EDs treating CYP must have the medical and nursing staff on each shift that is adequate to cope with 80% of predicted maximum demand	- Evidence of clinical workforce demand-capacity mapping complying with good practice (e.g. Emergency Care Intensive Support Team (ECIST) tool)	N/A

No.	Standards	Indicators	Evidence
15	Working practices for PEM consultants need to reflect the high intensity nature of their clinical work, and should adopt the recommended mitigations for job planning and rota design	• Job planning and rota design will be in accordance with good practice recommendations[98, 99]	RCEM. Sustainable working and PIPP RCEM. Workforce
16	All EDs treating CYP should have a lead for staff wellbeing, with appropriate time allocated for this role	• Evidence of appropriate staff facilities • Evidence of debrief and peer support activity in place (ability for staff to meet in a non-judgemental setting to be able to openly discuss challenging cases and situations) • Access to in-house psychology services.	RCEM, Staff Wellbeing RCEM, Job planning for substantive senior Emergency Physicians
17	All EDs treating CYP must employ (or have access to) a play specialist with additional training and experience in supporting CYP with complex needs. Availability of the play service should cover hours of peak demand, including evenings and weekends.	• Evidence of an appropriately trained on-duty play specialist (or access to a play specialist service) whose availability covers hours of peak demand, including evenings and weekends.	NHS England and Starlight. Play well: recommended standards for health play services

Practice Examples

Practice example 1: King's College Hospital: Youth workers (YW) embedded within the ED MDT

King's College Hospital has embedded youth work within its ED since 2007. Redthread (part of the Catch22 charity) provides invaluable support to CYP aged 11-24 who are victims of violence, at risk of criminal/sexual exploitation, and those up to 25 who are domestic abuse victims.

'In a 2022 study of our CYP, 16% reported feeling unsafe on social media, 13% being pressurised into sexual acts, and nearly 3% carrying weapons for protection or being asked to carry drugs/weapons for others.'

Approximately 60% of our referrals are for assaults, 10% for concerns around criminal or sexual exploitation and 25% for sexual violence.'

Redthread works directly alongside the EM team, engaging with CYP in these opportunistic "reachable" moments. They are experts in assessing the risk profile of presentations through a contextual safeguarding lens, advocating for CYP, ensuring their voice is heard by professionals and other agencies, and working with them to jointly create a safety plan.

'Our youth service has a mixed model of funding (from charity, central government, and the ICB), and together with acute health (Emergency Medicine), fills the gaps in provision that are currently present across CAMHS/Mental Health, social care, criminal justice and housing.

The impact of the cycles of violence and trauma on CYP means that undiagnosed PTSD and other mental health needs are the most common reasons for reattendance to ED after the initial YW service referral. Other models provide social prescribing or navigators, but our YW collaboration continues support beyond the acute admission to ensure a safe handover of care into the community.'

More details:

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Redthread kch-tr.redthread@nhs.net; https://www.redthread.org.uk/

Practice example 2: Collaborative working

The Paediatric Innovation, Education and Research Network (PIER) is a collaboration of multidisciplinary health professionals working to improve the care of CYP in the South of England through development of regional guidance, delivery of educational initiatives and paediatric research.

More details

Website: https://www.piernetwork.org/

Practice example 3: Imperial College Paediatric Society student-led volunteer play team

Imperial College's first Paediatric Society launched their student-led play volunteering programme 14 years ago. It was designed to support the vital work of play specialists, who are essential for a child's hospital experience, but face capacity challenges with limited funding. This wasn't just about providing extra hands - it was about redefining how medical students could actively contribute to paediatric care. The project involved:

1. **Planning and Preparation:**

- Forming a committee, including a dedicated team of students, faculty, and play specialists to drive the initiative.
- Assessing feasibility, including understanding funding needs, logistics, and ensuring long-term sustainability.
- Creating an action plan, including a recruitment strategy, stakeholder pitches, training and placement logistics.

2. **Safety and Compliance:**

- There were challenges in navigating regulations for volunteers in a clinical environment.
- While medical students typically had DBS checks and vaccinations, expanding the programme. to include non-clinical and non-medical students required additional safeguards .
- Safeguarding checks were integrated into the recruitment and training process, ensuring all volunteers met the necessary requirements.
- Collaboration with hospital management ensured adherence with infection control and safeguarding policies, creating a secure and safe environment.

3. **Stakeholders:**

Collaboration and engagement with the right stakeholders was crucial to the success of the programme

- University: Forming a medical school Paediatric Society was essential, which included writing proposals, business case pitches to university faculty members, and demonstrating the educational value of the initiative.
- Clinical teams: The success of the student play volunteer scheme was reliant on buy-in from the wider MDT. Emails, posters, and face-to-face meetings helped communicate the benefits, ensuring the programme was understood and supported at every level.
- Medical students: The experience offered invaluable benefits for the medical students' clinical skills, and they also developed their communication and teamworking abilities which are vital for their future clinical roles and in providing holistic care.

4. **Training Days:** were mandatory prior to volunteering to ensure full preparation of students.

- A focus on education and safety
- Talks from MDT members about hospital policies and infection control

Many thanks to: Nisha Patel, Dr. Bob Klaber (General Paediatrician) and Tina Halton (Play Specialist)

Chapter 4: Management of the sick or injured child

Receiving a child

The arrivals area of the Emergency Department (ED) should be monitored/observed by a suitably trained individual who is able to recognise the seriously unwell or injured child and respond accordingly. The receiving area of any Urgent and Emergency Care (UEC) setting should never be left unattended by clinical staff, as critically ill children often arrive unexpectedly by car, rather than by ambulance. All new arrivals must be kept in view while waiting, so that a deteriorating or critically unwell child can be quickly identified. The RCPCH safe system framework[100] provides online resources and tools to support staff and families in spotting the sick child.

All ED staff should routinely explain who they are and what service they can or cannot provide for the patient.

The Office for Health Improvement and Disparities (OHID) 'You're Welcome' standards[101] recommend that: "*Young people are treated with sensitivity, and any potentially sensitive questions are asked in private where they cannot be overheard - for example, away from the reception, waiting areas or clinical environment.*" All children and young people (CYP) and their parents or carers must be treated in an appropriate area with their privacy and dignity respected.

Initial assessment

The main objectives of an initial triage[102] are to:

- Identify patients with potentially life-threatening conditions and injuries to ensure those with the most time-critical conditions are prioritised.
- Accurately assess non-life-threatening conditions and injuries so that appropriate prioritisation occurs for these patients, including signposting or redirection to other services where appropriate.
- Recognise potentially vulnerable patients and consider their immediate safeguarding and any mental health concerns.
- Prevent ED crowding and support infection prevention and control (IPC).

Triage

All CYP should receive a structured assessment that follows a standardised system and is conducted by an appropriately trained nurse or doctor with paediatric competence within 15 minutes of arrival in the ED[103]. A rapid system of prioritisation must be implemented when the wait time to initial assessment exceeds 15 minutes.

The national triage acuity project will release further material in autumn 2025. This process involves having a primary assessment - a visual review by a clinical member of staff on arrival in the ED - followed by a secondary assessment by an appropriately trained nurse or doctor with paediatric competence (ideally within 15 minutes). This process would assign an acuity of 1-5 to each patient aligned to the Emergency Care Dataset acuity scale and is embedded into the ED National

Paediatric Early Warning Score (NPEWS) approach, also due to be released in autumn 2025.

Medically unwell CYP should have a brief history supplemented with a record of vital signs performed, a weight and a pain score. Some patients may be suitable for more rapid assessment, consisting of a brief history, focused physical examination and pain assessment. Triage should always include consideration of any safeguarding concerns or risk factors, as well as whether the child has an active child protection plan (England) or their name is on the child protection register[104] (Northern Ireland, Scotland and Wales). Triage should also identify if a child with complex needs, learning disability or autism has an Emergency Care Plan (ECP) or Hospital Passport, or if a child with a life-limiting condition has an Advanced Care Plan. For more information, see Chapter 5: Safeguarding in emergency care settings and Chapter 7: Children and young people with complex needs.

For those presenting with mental health concerns, an assessment of risk should be commenced, including consideration of the level of observation and support that the CYP requires to remain safe in the ED, and the risk of the CYP leaving the department before assessment or treatment is complete[105, 106]. For more information, see Chapter 6: Mental health.

Depending on local arrangements, 16- and 17-year-old patients may be given the choice of being seen in an adult or paediatric ED. Whichever environment they choose, they must be afforded the same quality of care as younger children, in line with their rights.

Vital signs

All CYP presenting with a medical illness or significant trauma should have a set of vital signs recorded to include temperature, oxygen saturation, respiratory rate, heart rate, capillary refill time, blood pressure (BP)[107] and a GCS or AVPU score[108]. CYP with abnormal vital signs should be prioritised accordingly, and the national triage acuity scale gives guidance on a format for this. Clear criteria should be in place for the immediate escalation of CYP presenting with critical illness or injury, including the activation of cardiac arrest, major haemorrhage and/or trauma teams without delay.

A Paediatric Early Warning System[109] (PEWS) that detects abnormal or deteriorating vital signs should be used for early identification of CYP requiring escalation, including those with potential sepsis. NPEWS charts are already established in Scotland and Northern Ireland and are due to be rolled out in Wales by September 2025. In England (at the time of publication), an NPEWS is in the process of being rolled out in hospital inpatient wards and an ED NPEWS pilot, aligned to the inpatient chart, is ongoing. In the interim, hospitals that already have a scoring system in their ED should continue to use that system[110]. Any CYP with abnormal vital signs identified at triage should have these observations repeated within 60 minutes, or earlier for serious conditions, in keeping with locally agreed early warning scores and triage category[107].

Initiating treatments and investigations

Triage staff should initiate relevant treatments, such as analgesia or an oral fluid challenge and investigations, such as urine collection, and prepare a child for blood sampling if likely, so that these processes are underway at an early stage in the care pathway.

Analgesia and pain scoring

Pain should be assessed at triage using an appropriate pain score, and analgesia for moderate and severe pain should be delivered within 20 minutes of arrival[111]. Pain should be reassessed after receiving the first dose of analgesia (within 60 minutes for patients in moderate to severe pain at presentation) and this supplemented as required, including with the support of a play specialist if needed. Protocols should be in place for the assessment and management of pain in CYP in the ED, and these should be audited annually[112].

RCEM provides pain assessment guidelines with valid tools for measuring pain intensity in CYP, including those with cognitive impairment or communication differences. Consideration should be given to CYP who cannot express their pain for any reason, which could include age, illness, injury or disability (For more information, see Chapter 7: Children and young people with complex needs). CYP should be provided with resources to help them communicate and to make informed choices regarding pain relief management. Where possible, the CYP's view should be central to the decisions made about their pain relief[113].

Re-direction

Many EDs are now signposting or re-directing patients to different care settings, both on arrival and pre-hospital. From the front door, CYP are typically first directed to the paediatric ED to undergo an initial triage. Re-direction may be carried out from there, for example, to UTCs designed to manage minor illness and injury, or to SDEC services for less urgent specialty review and investigation. It is essential that the re-direction of CYP is carried out by regulated healthcare professionals with paediatric competencies and experience in paediatric initial assessment, including basic observations. UEC and SDEC settings receiving paediatric patients must ensure that they are subsequently seen by competent clinical staff, who are trained in the assessment of CYP and recognition of the sick child.

Full assessment and treatment

A full assessment should be completed by a clinical decision maker with paediatric competence within 60 minutes (median time across presentations) or earlier, according to clinical urgency as identified at triage[114].

Clinical guidelines

It is well recognised that regularly updated, evidence-based clinical practice guidelines improve both the safety and quality of patient care[115, 116]. Departments should be equipped with a comprehensive list of clinical guidelines covering the common emergency presentations in childhood and adolescence. These may be locally produced, but should be in keeping with national guidance (e.g. NICE, Resuscitation Council, APLS).

Drugs, equipment, point of care testing, and other investigations

Facilities receiving sick or injured CYP should have an appropriate range of drugs and equipment, including those required for resuscitation and advanced airway management in accordance with the acuity level seen in that setting[117]. The Resuscitation Council UK, Association of Anaesthetists of Great Britain and Ireland (AAGBI), and Royal College of Anaesthetists (RCoA) all provide useful checklists[118, 119, 120]. Drugs and equipment should be regularly checked in accordance with local policy. Point of care testing should also be available including, but not limited to, blood glucose and blood gases, including lactate and electrolytes[121]. Emergency CT imaging should be available within an hour of request, 24 hours a day for MTCs and in other settings this would be expected as clinically indicated (e.g. to assist in the management of suspected neurosurgical emergencies, such as a blocked shunt or an intracranial haemorrhage)[122].

Hypoxaemia and airway complications are the most frequent causes of cardiac arrest in critically ill CYP managed in non-specialist centres[123]. UEC settings caring for CYP should have appropriately sized advanced airway equipment readily available to manage any airway difficulties. Pre-prepared cognitive aids are helpful in selecting the correct kit[124]. Where an artificial airway device is used, waveform capnography is required.

All staff managing the paediatric airway require training in practical airway skills and the use of relevant equipment, including capnography and other monitoring. There should be a clear escalation pathway and chain of responsibility for any CYP requiring airway support, ensuring that anaesthetic input is requested early if difficulties with airway management are anticipated[125]. Escalation may include discussion with other specialties such as ENT +/- transport services and clear policies should be in place to support this.

Resuscitation teams

EDs must have standard operating procedures in place for:

- The composition of paediatric resuscitation and paediatric trauma teams. This also applies for smaller hospitals, where they will need to consider the paediatric competencies of their resuscitation teams and identify senior decision makers, especially out-of-hours, where on-site senior support may not be immediately available.
- When and how to activate the paediatric resuscitation, trauma and major haemorrhage teams.
- Ensuring those managing paediatric airways are competent in all aspects of paediatric advanced life support.
- Pathways for escalation of care for any CYP needing airway support, including specific guidance relating to an anticipated difficult airway in line with the Difficult Airway Society's paediatric difficult airway guidelines[126].
- Resuscitation and stabilisation, including clinical guidelines for the management of acutely unwell or severely injured CYP, as well as those in extreme behavioural crisis (see Chapter 6: Mental health)
- Caring for parents during the resuscitation of a child

Communication with parents/carers

Parents, carers, and CYP should be supported throughout their ED attendance. Parents and carers should be updated regularly on their child's condition and management plan and their views, together with the view of the CYP, should be sought when making decisions about the CYP's care (with consideration of Gillick competence for those under 16 years old, mental capacity for those aged 16 years and older, confidentiality, and safeguarding if a CYP wishes to receive/refuse treatment without their parents' or carers' knowledge or consent).

> ***"My 6-year-old said the consultation was too long and the questions were not written for children to understand, so a lot of parental help was needed."*** Parent/ Carer, RCPCH& Us 2025
>
> ***"They talked to my Mum more than me"*** Young Person, RCPCH& Us 2025

Specific Considerations

Neonates

Babies under 1 month of age, especially those born before 37 weeks gestation and of low birth weight, are a particularly vulnerable group within the PED[127]. A substantial proportion of infants present with urgent medical complaints such as fever, vomiting and shortness of breath. However, ED attendances for less acute neonatal problems, such as jaundice, weight loss and feeding difficulties, are becoming increasingly common and local units should develop clear pathways for liaising with community practitioners to promote care at home, with access to breast-feeding and enhanced midwifery support. When babies do require admission to hospital for more intensive management of feeding problems or jaundice, pathways should be clearly outlined and locally agreed between paediatric and neonatal teams.

Major Trauma

Regional trauma networks have been operating for over 10 years in the UK with a substantial positive impact on patient outcomes[128]. Despite bypass protocols that encourage ambulances to transport trauma patients to the nearest MTC, it is recognised that some seriously injured children will be brought to the nearest hospital, sometimes by their parents, who are understandably unaware of a unit's trauma status.

All hospitals should have systems and equipment in place for the arrival of a seriously injured CYP who cannot be safely transported to the nearest MTC immediately. All EDs, regardless of adult/paediatric trauma unit status, must have access to an appropriately trained on-site team who can be called on to rapidly react and perform initial stabilisation of a severely injured CYP. A robust education, training and simulation programme for staff who would be involved in such cases will help reduce the significant stress and cognitive load that occurs during these high-pressure events.

In addition, clear pathways must be in place for effective reciprocal communication between district general hospitals, trauma units and the regional MTC. It is the role of the MTC Consultant, or Major Trauma Single Point of Contact (SPOC) in Scotland, to provide telephone support in such situations and lead on the joint decision making around ongoing care for the injured CYP. Policies should be in place that outline the management of a critically injured CYP when the receiving hospital is not an MTC. These should include guidelines for initial stabilisation, policies for communicating with the trauma network and the safe secondary transfer of critically injured children. For more information, see Chapter 10: Safe transfers.

Mental health

CYP presenting with mental health or behavioural problems should be triaged according to their clinical and situational urgency. Assessment tools to assist ED staff in identifying at-risk patients should be used to supplement the standard triage process (see Chapter 6: Mental health). Assessment by specialist CAMHS teams should usually take place in parallel with physical health teams[129]. As such, referrals to mental health teams can, and should be made early, to minimise unnecessary and extended wait times for these patients.

There is increasing evidence that multi-disciplinary 'Behavioural Emergency Response Teams' can help to safely de-escalate behavioural crisis situations and reduce the risk of harm for both patients and staff. Local providers may wish to develop this type of service, designing systems that rapidly bring together physical and psychiatric health professionals with appropriate security team support[130].

Pre-agreed pathways

For some CYP with complex needs, pre-agreed ECPs provide details on immediate management and resuscitation, as well as agreement on the admitting specialty. Patient held information, such as health passports, can provide additional information that should be considered when managing the CYP. Some CYP presenting with an individual disability or complex medical needs may not have a pre-written plan but may still require reasonable adjustments. See Chapter 7: Children and young people with complex needs for more information.

Children with life-limiting conditions

Advanced care plans are often held by the parents or carers of CYP with life-limiting conditions to ensure care in the ED is tailored to their individual needs. However, ED staff should remain adaptable and reactive to the patient's current presentation and the wishes of the CYP and parents or carers. See Chapter 7: Children and young people with complex needs for more information.

Safe discharge from emergency care settings

Senior review

Policies should be in place to determine those situations where review by a senior decision maker is routinely required before patient discharge. These can be locally developed, and examples could include, but are not limited to, CYP with the following:

- Fever under 3 months of age
- Persistently abnormal observations on a PEWS chart
- Re-presenting within the same illness or injury episode
- Complex needs (For more information see Chapter 7: Children and young people with complex needs)
- Fractures, burns, bruising or injuries under 12 months of age
- Any parental disagreement with a plan to discharge home
- Any safeguarding concerns, including all unaccompanied adolescents presenting to the ED, and all children on a Child Protection Plan (England) or the Child Protection Register (Northern Ireland, Scotland and Wales)

These clinical scenarios should trigger a review (which may be a discussion or a face-to-face encounter) with a senior decision maker prior to discharge[131]. EDs should ensure local policies are in place to support this, in line with local staffing models and the frequency with which children are assessed at that ED[132]. In other environments, such as UTCs, referral to a paediatric centre should be initiated when appropriate.

Safety netting

Good safety netting ensures that CYP and parents or carers have the right information, available in the right format, to make the right choice about where, and when, to seek further healthcare advice. Several helpful resources about common childhood conditions are available, including the Healthier Together Website[133]. Safety-netting advice should be specific about which services to direct CYP and parents or carers towards, should they require further care or clinical review, acknowledging that ED may not always be the most appropriate or accessible choice. Further information is available in Chapter 8: Health improvement and health inequalities.

Hospital at Home/Ambulatory follow-up care

Hospital at Home teams are increasingly available to provide ongoing hospital-level care and monitoring in the community for a number of common medical conditions such as bronchiolitis, gastroenteritis and viral induced wheeze. These teams can help ensure safe discharge by providing ongoing support and education for patients at home. They also help to improve patient flow by avoiding admission and facilitating earlier discharge (see PATCH Practice Example below).

Standards

No	Standards	Indicators	Evidence
18	CYP should be easily visible in the waiting area of all UEC settings and a formal triage assessment should be undertaken within 15 minutes of arrival to determine priority category. This assessment should be supplemented by a full record of vital signs, a weight and a pain score for all CYP presenting with a medical illness or significant trauma	• Evidence of appropriate waiting area design that allows clear visibility on arrival • Audit evidence of the percentage of CYP who undergo triage within 15 minutes of arrival • Audit evidence of a record of pain score for all CYP presenting with an illness or injury and full record of vital signs for all CYP presenting with an illness or significant injury	NHS England. 2022. Guidance for emergency departments: initial assessment RCEM. 2017. Management of Pain in Children
19	Sufficient staff resource and space should be allocated for triage areas to cope with fluctuations in, rather than average, demand (both in terms of patient numbers and time taken to complete triage) A rapid system of prioritisation must be implemented when the wait time to triage exceeds 15 minutes	• Evidence of an appropriate escalation policy if the wait time for triage exceeds 15 minutes	NHSE. 2022. Guidance for Emergency Departments: Initial Assessment NHSE
20	All CYP who are streamed away from a UEC setting must have been assessed by a regulated health care professional with the necessary paediatric competencies and experience in paediatric initial assessment	• Evidence of a qualified practitioner with paediatric competencies streaming CYP • Evidence of the use of criteria-based, consistent processes for streaming CYP e.g. agreed clinical guidelines[102, 134]	RCEM. 2017.Initial Assessment of Emergency Department Patients NHSE. 2022. Guidance for Emergency Departments: Initial Assessment NHSE Emergency Department Guidance Signposting/ Redirection Best Practice Guidance

21	CYP with abnormal vital signs at triage should have these repeated within 60 minutes, or in keeping with locally agreed PEWS and triage category (For example, an unwell looking patient with abnormal observations and a high triage category should be in the resuscitation area or Majors on continuous monitoring, whereas a well looking patient with a fever and mild tachycardia and a lower triage category could reasonably wait up to an hour to have their observations repeated)	• Evidence of compliance with the RCEM Vital Signs in Children Audit or similar local audit	RCEM. 2016. Vital signs in children
22	All EDs treating CYP should use an appropriate Paediatric Early Warning System (PEWS) for recording patient observations	• Evidence of use of a defined PEWS	RCPCH, 2025, UK Paediatric Early Warning Systems (PEWS)
23	All EDs should have policies in place for the immediate escalation of care for a critically ill or injured CYP	• Evidence of a system for rapidly alerting the paediatric resuscitation team to support in the escalation of care for a critically ill or injured CYP	
24	All EDs treating CYP must have an appropriate set of clinical guidelines and range of drugs and paediatric equipment available	• Availability of a set of evidence based clinical guidelines • Compliance with drugs and equipment listed in Resuscitation Council UK 'Quality Standards for Cardiopulmonary Resuscitation Practice and Training'[118] • Major Trauma Centres and Trauma Units should additionally stock the drugs and equipment required to stabilise a severely injured child in line with trauma network protocols	Resuscitation Council UK. 2023. Quality standards for cardiopulmonary resuscitation practice and training AAGBI. Anaesthetic Equipment Checklist
25	Analgesia must be dispensed for CYP with moderate and severe pain within 20 minutes of arrival in the ED and their pain score reassessed and acted upon within 60 minutes.	• Evidence of compliance with the RCEM Pain in Children audit or similar local audit[111]	RCEM. 2017. Management of Pain in Children
26	All EDs treating CYP should have agreed policies in place for specific patient categories who require review by a senior decision maker prior to discharge	• Evidence of agreed policy on those patients requiring senior decision maker review	N/A

Practice Example

Practice example 1: North West London: Providing assessment and treatment for children at home (PATCH)

The PATCH programme is an innovative, nurse-led model of care enabling the treatment of acutely unwell children at home rather than in hospital. It was launched at St Marys Hospital, part of Imperial College Healthcare Trust, London, in 2016. The model is now fully established across five hospital trusts, providing 7/7 care at home for children in Northwest London, with up to three-times-a-day home visits augmented by telephone and video review as required. Pathways include treatment of viral-induced wheeze and asthma, gastroenteritis, bronchiolitis, croup, administration of IV antibiotics and jaundice management, including at-home phototherapy.

The service aims to avoid admission, reduce length of stay and prevent paediatric ED attendances and reattendances. One PATCH team reported bronchiolitis admissions to have halved at their Trust after its first year of operation, and a 10% reduction in ED reattendances within three days. Across Northwest London, PATCH saved a total of 3317 bed days in 2023/24, at a cost saving of over £0.5m to the sector.

Feedback from acute trusts and the wider system demonstrates that PATCH has helped to improve flow and capacity across pressured paediatric UEC and acute pathways. Nursing staff satisfaction and development opportunities have also improved, leading to retention of nursing talent within the sector, and aligning with NHS Long Term Workforce Plan aspirations. Parents report improved confidence in managing acutely unwell children at home. This is reflected by 100% positive family feedback, as well as reported socioeconomic benefits due to reduced disruption to family life, work and school.

PATCH continues to grow and has an ambitious vision for the future, including widening its scope by accepting referrals directly from GPs, UTCs, 111 and the London Ambulance Service, and increasing capacity by enabling remote monitoring of patients through technological innovation. This aligns with the NHS 10 Year Health Plan's[26] aims for a digital shift and to move care from hospitals to the community.

Chapter 5: Safeguarding in emergency care settings

Safeguarding encompasses promoting the welfare of children and young people (CYP), protecting them from maltreatment, preventing impairment of their health or development, and ensuring they grow up happy, healthy and safe from harm. Child protection refers to activities undertaken to:

'Identify and prevent children suffering, or likely to suffer, from significant harm[135]*; manage children who have been identified as suffering from, or likely to suffer, significant harm.'*

Urgent and emergency care (UEC) settings may be the first point of contact with a health professional for CYP who are experiencing, or who are at risk of abuse and or neglect. It is vital that health professionals in UEC settings recognise, protect and take an active role in preventing the abuse of CYP.

Children of different developmental stages often have varying safeguarding needs, and UEC settings must have systems and processes in place to safeguard all CYP, including those whose voices may be underrepresented.

Safeguarding and child protection guidance

It is a statutory requirement in the UK for all health care organisations to actively safeguard and promote the welfare of CYP[136]. They must also co-operate with other agencies to protect CYP from harm. Each nation has guidance outlining the duties and expectations of staff working in UEC settings[135, 137, 138, 139]. Other essential guidance for staff in this area includes:

- NICE guidance: Child maltreatment: when to suspect maltreatment in under 18s[140].
- General Medical Council: GMC child protection guidance: Protecting children and young people: the responsibilities of all doctors[141].
- RCPCH Child Protection Companion[142].
- RCPCH Physical signs of child sexual abuse 2025 [143].

Information on the child protection systems for each nation of the UK including legislation, practice and guidance can be found on the NSPCC Learning webpages[144].

Identifying and reporting safeguarding concerns

It is crucial that all UEC staff with direct patient contact can identify CYP who are at risk of, or who have suffered from, any form of child abuse (see Chapter 3: Workforce and training). Identification involves the early recognition of vulnerable CYP, targeting support for the most vulnerable (including assessments and referrals to other services) and clarity around accessing support. There must be clear protocols when abuse is suspected, with relevant and specific information for each unit on how to access safeguarding advice and what actions to take when welfare concerns are identified. Everyone with direct patient contact working in UEC settings should also be encouraged to reflect on their interactions with CYP, and to adjust their practice to ensure a child-focused approach.

There should be a system in place to allow the rapid identification of CYP who have been repeatedly brought to UEC settings and/or who have already received advice from remote or other urgent healthcare settings (See Glossary Definition of a Frequent Attender).

When a child self-presents without an accompanying adult with parental responsibility, all possible measures should be taken to contact a person with parental responsibility, and (with appropriate consent and considering Gillick competence and/or Mental Capacity - depending on the age of the child) share information about that child and their health needs. All unaccompanied adolescents presenting to an ED should be discussed with a senior decision maker and consideration given to their safeguarding needs. Where it is not possible to contact a person with parental responsibility, a low threshold should be adopted for initiating safeguarding processes, and the CYP should not be discharged without confirmation they have a responsible adult to go to at home and consideration is given to how the CYP will be safely transported home. Youth worker involvement may be helpful in selected cases.

If a CYP is suffering, or likely to suffer, significant harm, a local authority may make them the subject of a Child Protection Plan (in England) or add them to a Child Protection Register (in Northern Ireland, Scotland and Wales)[145]. All UEC settings should have a robust system in place to identify whether a child is subject to a Child Protection Plan (England) or registered on the Child Protection Register (Northern Ireland, Scotland and Wales). For further details, see the 'Information sharing' section below. The attendance of these CYP and those at high risk of a potential safeguarding presentation (e.g. non-mobile infants presenting with injuries such as bruising, burns or fractures), should be reviewed by a senior decision maker with the necessary clinical (including clinical safeguarding) competencies. Appropriate action should be taken, which may include exploration of the causes for attendance with the multidisciplinary child protection team, including the relevant local authority.

> ***"Maybe asking more specific questions and enquiring if something seems wrong, offering them support and a safe environment to open up"*** Young Person, RCPCH& Us 2025

Children with additional or specific safeguarding risks

Some groups of CYP have additional or specific safeguarding risks and it is important that their needs are accommodated on an individual basis, as well as having robust procedures to ensure protection of these groups. These individuals should be identified on arrival at any UEC setting and may include CYP with complex needs or learning disabilities, those who are cared for by a local authority, children and young people seeking asylum and refugees (CYPSAR), and CYP who are involved in the criminal (youth) justice system. Additionally, systems must be in place in all UEC settings to review cases where CYP leave before the assessment is completed, are not brought back for scheduled follow-up, or are not brought for an initial agreed assessment.

Members of the multidisciplinary team (MDT), including those predominantly or exclusively working with adults in UEC settings, must be particularly aware of families with complex and multiple needs. Parental factors such as substance misuse, domestic abuse, and mental health concerns can increase the risk of harm to CYP. Further consideration may also be necessary for parents/carers of CYP who have complex needs (and may need referral for support), are care experienced (were in care when they were less than 18 years old), or are foster or kinship carers.

It is the responsibility of those health care professionals working in adult settings to recognise and respond to safeguarding concerns[146, 147]. This includes remaining up to date with the latest relevant legislation around mandatory reporting of different types of child abuse and/or injury mechanisms (see above for further information). Health care professionals working in adult settings must also be aware of mandatory reporting requirements for Female Genital Mutilation (FGM) in young people under 18 years old, acknowledging this may be linked to a concern for an adult who has undergone FGM or related disclosure[148].

Appropriate knowledge, skills and competencies are obtained through training[149], and support should be available from safeguarding leads within a department and senior practitioners. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring that safeguarding training is in place.

Recognising all forms of abuse

Staff providing UEC for CYP must be competent in recognising different forms of abuse within the statutory categories, outside of the well-known forms (physical abuse, sexual abuse, neglect, and emotional abuse). This may include child sexual exploitation, fabricated or induced illness[150], gang- or group-related risks, criminal exploitation, peer-on-peer violence, human trafficking[151], domestic abuse[152], forced marriage and crimes perpetrated in the name of honour.

All professionals interacting with CYP should undertake ‘Prevent’ training, as recommended by the Home Office[153], which aims to safeguard vulnerable individuals from radicalisation into terrorist action or supporting terrorism. Similarly, undertaking training to recognise FGM[154], or to acknowledge a disclosure from a CYP who has had FGM performed is vital. While health professionals in England and Wales must report known cases of FGM in under 18-year-olds to the police[155], it is clinically essential for all healthcare professionals in UEC settings to identify this type of abuse, regardless of their jurisdiction.

Information sharing

Robust systems should be in place to inform the primary care team about each CYP’s attendance at a UEC setting[156]. This should include the GP and the community midwife, health visitor, school nurse (depending on the age of the CYP) or Looked After Children nurse, as appropriate. The information supplied should be sufficient to enable those teams to make their own safeguarding assessments. The UEC system often holds vital safeguarding information, and this must be securely shared with other services in a way that can be used to ensure appropriate protection.

There must also be a national focus on securely sharing information between local authorities and NHS organisations to better identify children who are subject to a child protection plan, or those whose name appears on a child protection register, as well as those children who are cared for by a local authority (looked after children) when they attend UEC settings. For example, in England, the Child Protection Information Sharing (CPIS) system connects the systems used by local authority children’s social care teams with those used by NHS urgent care settings[157]. Other UK nations have corresponding information sharing systems including Getting it right for every child (GIRFEC) in Scotland[158]; Working Together to Safeguard People: Information sharing to safeguard children in Wales[159]; and Guidance on Information Sharing for Child Protection Purposes in Northern Ireland[160].

Where electronic systems are not enabled, it is essential that all relevant members of the multi-disciplinary team know the procedures for determining the child protection status of any CYP attending a UEC setting at any time.

In the case of a CYP presenting with a wound caused by a gun, or from an attack with a knife, blade or other sharp instrument, the police should be informed immediately[161]. Recognition and referral of CYP with injuries caused through fighting or being attacked by peers is good practice. Increasingly, a number of EDs have embedded specialist liaison youth workers to work with young people following ED attendance to minimise behaviours putting them at risk of injury such as, for example, Navigator Projects commissioned by Violence Reduction Unit(s)[162]. For more information on youth workers in UEC settings, see Chapter 3: Workforce and training.

Appointing a liaison health professional can enhance information sharing. This role and scope of work will vary, but aligns with the number of CYP requiring safeguarding, the availability of the UEC setting's named doctor and named nurse for safeguarding, and availability of information from children's social care.

Workforce and training

All UEC settings should have a lead consultant and a lead senior nurse holding shared responsibility for child protection. All members of the multidisciplinary team working in UEC settings should have access to training and ongoing supervision in child protection appropriate to their role. Detailed requirements are contained within the intercollegiate safeguarding competencies.

> ***"Doctors and health workers should be trained in listening without judgment, understanding how trauma or difficult life experiences affect young people, and being more aware of issues like bullying, online safety, and social media pressure. They should also learn how to spot early signs of mental health struggles and know how to support us in a calm, respectful way"*** Young Person, RCPCH& Us 2025

Standards

No	Standard	Indicators	Evidence
27	All health professionals who regularly care for CYP should have up-to-date safeguarding training and competencies in line with the *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*	- Workforce training logs demonstrating compliance	Looked after children- Roles and Competencies Adult Safeguarding: Roles and Competencies Adult Safeguarding: Roles and Competencies
28	All UEC settings should have clinical guidelines in place for safeguarding CYP, which are bespoke to the individual local inter-agency arrangements and which incorporate the relevant statutory guidance	- Evidence that safeguarding clinical guidelines are available and easily accessible	N/A
29	All EDs have in place a lead consultant and a lead nurse with shared responsibility for child protection within the department	- Evidence of a lead consultant and a lead nurse is included within the service's Standard Operating Procedure document	Safeguarding children and young people- roles and competencies

30	Information from a Child Protection Plan/Register is available to relevant professionals working in UEC settings 24/7, preferably through shared secure electronic information systems, or alternatively via a duty social worker	- Evidence of how and when to access this information, or a duty social worker, is included in the service's Standard Operating Procedure document - Implementation of nationally approved information sharing systems	England: The Child Safeguarding Practice Review Panel: Child Protection in England Northern Ireland: Guidance on Information Sharing for Child Protection Purposes Scotland: Getting it right for every child (GIRFEC) Practice Guidance 4 Wales: Sharing information to safeguarding children
31	All staff working in UEC settings have access to safeguarding advice 24/7 from a paediatrician with adequate child protection expertise	- Evidence of access to a Child Protection rota	Safeguarding children and young people- roles and competencies
32	Systems are in place to identify and respond appropriately to CYP who attend UEC settings frequently	- Electronic system that captures frequency of UEC attendance	Frequent Attendance in the Emergency Department: Delivering Interventions and Services for High Intensity Use
33	CYP whose presentation indicates that they are at risk of significant harm (e.g. those on a Child Protection Plan/ Register, non-mobile infants presenting with injuries such as bruising, burns or fractures, or perplexing presentations including potential Fabricated or Induced Illness) must be reviewed by a senior decision maker with the necessary competencies prior to discharge	- Audit of attendances for CYP who are at risk of significant harm	Safeguarding children and young people- roles and competencies
34	GPs and other relevant members of the community child health team (midwife/ health visitor/school nurse/ children's community nurse/named social worker/ specialists) are informed of the attendance of a CYP (including care leavers) at a UEC setting within an agreed time frame	- Evidence that discharge summaries are sent to the GP, other relevant members of the community child health team and named social worker as appropriate within 24 hours of UEC attendance[163]	N/A

35	Standard operating procedures are in place to review cases where CYP leave, are taken or abscond from a UEC setting before being seen or before discharge, or who do not attend follow up, with escalation in real-time to the appropriate multi-agency child protection team where concerns have not been immediately addressed or mitigated. Escalation policies should be in place with CPS and police colleagues	- Policy available to all members of the healthcare team - Contemporaneous ED case note review	The Patient Who Absconds
36	All UEC settings seeing CYP where safeguarding issues have been identified should have access to child protection peer review sessions run in accordance with the RCPCH Child Protection Peer review guidance	- Audit of attendance at peer review sessions - Session dates and times available to all clinical members of the team - Protected time is available to enable team members to attend child protection peer review	Peer Review in Child Protection

Practice examples

Practice example 1: Alder Hey Children’s NHS Foundation Trust: Safeguarding reflection sessions

Alder Hey Children’s NHS Foundation Trust in Liverpool has a busy ED seeing around 75,000 children a year. Safeguarding is a key concern due to local levels of social deprivation and rising levels of youth violence and child exploitation.

Safeguarding reflection sessions are monthly meetings which provide a “safe space” for members of the ED and the hospital’s Safeguarding teams to discuss some of the more challenging and emotive cases seen in a busy ED with an inner-city location. All members of the MDT are welcome, including nurses, ACPs and medical staff.

Cases are nominated for the agenda by either team. This is often when the case has highlighted an area of uncertainty or learning for staff, and when there have been issues or barriers to care. One staff member will volunteer to give a brief case outline to those at the meeting, and this is recorded on a simple form. The case outline is followed by team reflection and discussion, and some learning points are normally drawn out of the discussion. Any actions from the discussion are also recorded on the form.

The ED staff learn a great deal from the Safeguarding team sharing their expertise and specialist knowledge. This can be about many aspects of the cases, from interpretation of injuries, history taking, communication and safeguarding procedures with social care and other teams. The meetings are also useful for the Safeguarding team to appreciate the pressures that the ED team may be under when trying to manage these cases, and the issues this can cause. The opportunity to come together and communicate openly, in a non-judgemental and reflective manner leads to strengthened working relationships between the two teams, and the ability to focus on learning points that are specific and practical to safeguarding within the paediatric emergency setting.

To extend the reach of this learning, a monthly poster is produced (see examples below). These are displayed in the ED on our two education boards. They are also emailed to all ED staff, shared with the Safeguarding team, and shared via our ED Education WhatsApp group. Recent topics and learning points of the month are also presented at the ED daily lunchtime “10-minute teaching” sessions.

The safeguarding reflection sessions get excellent feedback from our ED staff, and the Safeguarding team also appreciate the opportunity for positive discussion and teaching.

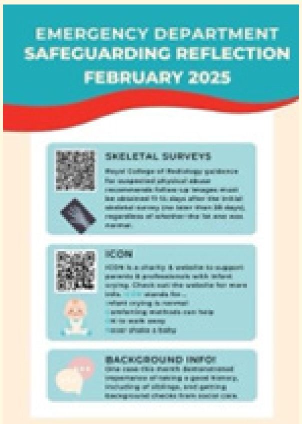
SAFEGUARDING REFLECTION
APRIL 2025

SOCIAL HISTORY

SEXUAL ABUSE

PEP & EMERGENCY CONTRACEPTION

CHAIN OF EVIDENCE



EMERGENCY DEPARTMENT
SAFEGUARDING REFLECTION
FEBRUARY 2025

SKELETAL SURVEYS

ICON

BACKGROUND INFO!

More details:

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Practice example 2: North Middlesex University Hospital: Adolescent grab bags

The North Middlesex University Hospital is the busiest paediatric ED in London, seeing around 55,000 children annually. The hospital serves a diverse and highly deprived population with high indices of child poverty. Young people accessing services include those hardest to reach, specifically those who do not regularly attend school/college. Gang violence and child sexual exploitation are amongst the many challenges facing these young people.

This project uses drawstring ‘grab bags’ in the ED to deliver key information on vulnerabilities including child sexual exploitation, sexual health (including LGBTQ+), drugs, alcohol, mental health, gangs or organised groups, and knife crime. The ‘grab bags’ are one strand of a larger bi-borough multi agency project which aims to target child sexual exploitation, gang activity and missing children, with a focus on joint working and data sharing across Enfield and Haringey.

The bags were created in consultation with young people and were resourced by multiple agencies. The contents include information leaflets, pocket-sized cards with useful numbers and websites, a consent quiz, and a lip salve with a domestic abuse helpline printed as a secret barcode. For those aged 13 years old and above, condoms are included.

The project was evaluated through questionnaires completed by young people aged 12 – 17 years old (59% female, 41% male). The bags were scored from 0 (“completely useless”) to 10 (“amazing”), with a range of 2-10 and an average score of 6.7. The most interesting or useful items were thought to be drug information (42%), condoms (35%), helpful numbers/websites (35%) and the lip salve (29%). 55% felt the bags were a good way of disseminating information and only 13% would not recommend them to a friend.

The cost of this project including the cost of the materials and resources to produce 1000 ‘grab bags’ was £5000. Each agency donated the resources to highlight their service, and each borough sponsored the project by donating £1000.

The initial questionnaire responses plus verbal feedback given to ED staff have been very positive. Anecdotally, a number of missing children have presented to our ED and if even a small number of those vulnerable young people are helped by this project, it will be very worthwhile.

What should you do if you are considering replicating the project:

- find out what other agencies (statutory and non-statutory) and resources are available to young people, for example specific teenage sexual health clinics.
- have a meeting with these other agencies and pool resources and ideas.
- run a focus group with young people to find out their views before producing the ‘grab bags’.
- audit and evaluate the project with a feedback questionnaire.

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Chapter 6: Mental health

Current challenges

Increasing demand

Mental health concerns in children and young people (CYP) are common and increasing across the UK. The recent NHS Digital CYP Mental Health Survey in 2023 found that 20% of CYP aged between 8 to 16 years had a probable mental health disorder, up from 13% in 2017[164]. National child mortality data show that in 2024, suicide or self-harm was the second leading cause of death in children aged 10-17[165]. Wider societal, economic and environmental factors have negatively impacted the mental wellbeing of many CYP, and this was only further exacerbated by the COVID-19 pandemic.

Child and Adolescent Mental Health Services (CAMHS) saw a 53% increase from 2020-2024 in the number of CYP presenting in mental health crisis and needing emergency support[166]. There are long waiting times to access CAMHS services following referral, with over 270,000 CYP awaiting mental health support after being referred to CAMHS in 2022-23[167]. Patients are waiting for an average duration of five months after GP referral and, in the worst cases, almost two years for a community mental health service appointment[168].

Legislative context

The Mental Health Act 1983[169] plays a crucial role in Emergency Departments (EDs) by outlining the legal framework for assessing, detaining, and treating CYP experiencing a severe mental health crisis. In 2025, a new Mental Health Bill began to move through parliament which seeks to make a range of changes to modernise the Act. The Royal College of Paediatrics and Child Health (RCPCH) will analyse any changes to the Mental Health Act 1983 as the new Bill passes through parliament and will publish further information regarding subsequent changes to practice. It is important that practice within the ED is in accordance with the Mental Health Act 1983 and any future updates. ED staff should have knowledge and training in the legal frameworks in the jurisdiction of the UK nation in which they are working regarding mental health, capacity, competence, parental responsibility and safeguarding.

Funding issues

Funding for CAMHS and community CYP mental health pathway services also poses a challenge and exacerbates these pressures. Despite progress through the ‘Five Year Forward View for Mental Health’ and the Royal College of Psychiatrists (RCPsych) document ‘Next Steps for Funding Mental Health Care in England’[170], which pledged investment in mental health and the introduction of a CYP waiting time standard[171], funding levels remain inadequate.

Workforce issues

Improving accessible community-based early interventions, with clear pathways to designated outpatient clinical services can help prevent CYP from reaching mental health crisis[172]. However, RCPsych analysis of NHS Digital workforce data showed that there has been a 6.3% decline in Child and Adolescent Consultant Psychiatrists since 2013[173]. The 2021 Census data showed a 14.8% Consultant vacancy rate and 11.7% Specialist, Associate Specialist and Specialty (SAS) doctor vacancy rate for CAMHS across English Trusts, with similar figures across the rest of the UK[174]. For CYP to receive the right care at the right time, it is essential that there is a systematic and multidisciplinary approach, as CYP require support from a range of professionals. The wider workforce data is more encouraging, with Health Education England's report: Children and Young People's Mental Health Workforce Census[175] describing a 70% increase in the combined CYPMHS workforce between 2016 and 2022 when including the independent, local authority, voluntary community and social enterprise sectors and youth offending teams.

Urgent and Emergency Care (UEC) pressures

The increase in the number of CYP requiring mental health support, coupled with the lack of sufficient capacity and funding for CAMHS, both in the community and inpatient settings, has seen an increase in the number of CYP presenting to health services with more acute mental health concerns, or in mental health crisis. Timely access to mental health support in their own community and close to home, is vital to prevent CYP reaching crisis point, yet 85% of CAMHS providers say they are under pressure and struggling to keep up with the increasing demand[176].

This has resulted in a rise in UEC attendances and hospital admissions for CYP with significant mental ill health, attempted suicide, self-harm, and eating disorders[164]. The management of mental health concerns for CYP in EDs presents its own challenges. Reports show that many CYP are waiting over 12 hours from arrival before being seen by a mental health professional, with some reporting waits of up to 5 days[177]. This increase in the length of wait from time of arrival in ED is due to a number of factors, including the lack of uniform provision of 24/7 mental health services for CYP, an increased complexity in presentations requiring multi-agency support, poor patient flow through hospitals and a significant mismatch between the demand for, and capacity to provide, mental health services. This subsequently manifests as prolonged waits for CAMHS assessment, a Mental Health Act assessment or the availability of a bed in a mental health ward[178].

> ***"Emergency mental health support is inadequate. Have to wait for 72 hours for a call back from emergency CAMHS. After 72 hours, the record is deleted"*** Young Person, RCPCH& Us 2025

Caring for CYP with mental health needs in the ED

EDs often represent the first point of contact for vulnerable CYP seeking help in a mental health crisis and where there is a lack of safe alternatives. The combination of rising demand and increasing waiting times, means that more CYP are presenting to EDs at a mental health crisis point. When CYP with acute mental health issues present to an ED, care should be provided in a calm and private environment by appropriately trained and experienced staff[179]. Therefore, it is essential that ED staff have the right skills and competencies to identify and manage CYP presenting with mental health needs[180].

Initial assessment

Appropriate screening processes should be used to identify mental health concerns and associated risks, such as substance misuse, in CYP. Specifically designed mental health triage tools can be helpful for this purpose, as well as using psychosocial screening tools, such as the HEEADSSS web-based app (See Chapter 8: Health improvement and health inequalities for more information) to identify relevant risk and protective factors related to adolescent health and wellbeing. Details of who has parental responsibility should be established on presentation for all CYP presenting with mental health concerns. Details of any existing care plans, health passports or similar documents (sometimes referred to as ‘all about me’ or ‘getting to know me’ documents) which the CYP may have, should be sought at the earliest opportunity.

CYP presenting in mental health crisis may have experienced family instability and mental health stigma before reaching the ED, which staff should be aware of. The education and social care sector may refer to this cohort of CYP as having social, emotional and mental health (SEMH) concerns. Staff should also be able to identify mental health concerns in CYP presenting with persistent physical symptoms. Mental health assessments should be explicitly non-judgemental and sensitive to the specific needs of the CYP. Organisations have called for specialised training to enable ED staff to improve their assessment and care of CYP experiencing mental health issues[181].

Physical environment

EDs are usually busy, noisy, brightly lit environments, and such settings can be distressing for CYP with mental health issues, exacerbating levels of upset or causing the CYP to leave the department before being seen.

CYP experiencing mental health issues, or emotional or behavioural distress, may find it helpful to wait and subsequently be seen in a space which is quiet, has a door, and is less bright. Where possible, noisy equipment should be minimised. Tools such as ear defenders can be useful. Audio-visual separation from the rest of the department helps to minimise sensory stimulation for distressed and agitated CYP. These mitigations help to manage risk and keep the CYP, other patients and staff members safe. Further information about the environment of EDs can be found in Chapter 2: Environment in paediatric emergency care settings.

> ***“The hospital environment is not supportive for young people having a mental health crisis in A&E”*** Young Person, RCPCH& Us 2025

Multiple complex needs

Physical and mental health needs frequently coexist. Nearly three quarters of CYP with a mental illness also have a physical health or developmental problem. There are complex interactions between physical and mental health. Co-occurrence is common and often leads to poorer outcomes[182]. This means it is likely that many of the CYP seen in EDs for physical health problems will have experienced poor mental health or may have a diagnosed, or undiagnosed mental illness[180].

Mental health assessment

EDs should ensure that physical and mental health needs are assessed and managed in parallel, to prevent CYP experiencing a disjointed service and unnecessary delays between assessments. CYP presenting with mental health issues for the first time, should be given a full physical examination and organic pathology should be excluded or confirmed. An appropriate risk assessment should be commenced at triage for all patients presenting in mental health crisis. This should include consideration of the level of observation and support that the CYP requires to remain safe in the ED[129, 183]. This risk assessment will inform the initial management of CYP in the ED, and the identification of any potential patient and staff safety issues whilst waiting for an assessment by mental health services. The Royal College of Emergency Medicine (RCEM) has developed a toolkit to support the provision of high-quality mental health care in EDs[184].

Crisis care management plan

If individualised crisis care management is necessary, the CYP and their parent or carer should co-author their crisis care plan, which should be circulated to relevant agencies in health, education, social care, the judiciary and the third sector.

Where electronic records exist, the crisis care management plan should be clearly located and identifiable. The CYP's ED attendances should be recorded to ensure information sharing with other health professionals. Where CAMHS services use separate IT systems to record clinical encounters, it is essential that such records are available to ED staff. Local guidelines should be consulted to arrange follow-up CAMHS appointments as necessary or appropriate, and all CYP presenting following a mental health crisis must be referred for CAMHS review within seven days[185].

Developing and maintaining strong links between EDs, CAMHS, education and social care services is important to ensure that appropriate and timely holistic support is available for CYP in crisis.

Self-harm

Self-harm is most commonly seen in CYP aged between 11 and 25 years old. Most CYP who have self-harmed can be managed out of hospital, depending on local provision of CAMHS support to the ED. NICE guidelines state that for CYP presenting following self-harm, a biopsychosocial assessment should be carried out by an appropriately experienced mental health professional[129].

As part of a documented process, CYP presenting following self-harm should be asked for consent to check for (and remove from their possession) any sharp objects (such as razor blades or knives) that raise concern of further self-harm in the clinical environment.

CYP who are admitted to an observation unit, short stay unit, remain in the ED for a prolonged period, or on a paediatric ward following an episode of self-harm should have:

- Access to CAMHS or age-appropriate liaison psychiatry telephone advice 24 hours a day.
- A joint daily review by both the paediatric team and CYP mental health team.
- Daily access to their family members or carers.
- Regular multidisciplinary meetings between the general paediatric team and mental health services.
- The opportunity to speak with a health professional without their parent/carer present.

Restraint

In situations where a CYP becomes highly distressed and their behaviour puts themselves or others at risk, preventative measures such as calming methods and other de-escalation techniques, including minimising or removing environmental stimulation or addressing unmet physiological needs, should be used in the first instance. Pharmacological and physical restraint should be regarded as a last resort, should only be utilised when judged to be in the best interests of the CYP and should be proportional to the risk to self and others[169, 186]. Restraint, both pharmacological and physical, should be conducted in accordance with clear local clinical guidelines. Staff should be appropriately trained, CYP should be closely monitored for signs of deterioration, and staff should ensure that the reasons for restraint are communicated clearly with the CYP and their parent/carer. Details of the episode and communication with CYP/parent/carers should be recorded using hospital incident reporting systems.

Leaving against advice

Any CYP leaving the ED against the advice of health professionals (with or without an accompanying adult) should trigger local safeguarding procedures[187]. ED staff should have written guidance with actions to take if a CYP leaves against advice, and on when it is appropriate to contact the police.

Section 136 of the Mental Health Act

Section 136 of the Mental Health Act 1983 (MHA 1983)[188] applicable to England gives police the legal power to a) remove an individual to a place of safety, or b) keep the person at a place of safety or remove the person to another place of safety if they appear to be suffering from a mental health problem and are deemed to be in immediate need of care or control. Section 136 cannot be used if the patient is in a private dwelling, or in any outdoor garden or garage related to a private dwelling, but can be used in hospitals and EDs. Under section 136 of the MHA 1983, a place of safety can include a hospital so, depending on local protocols, CYP under a section 136 may be brought to their local ED.

The Home Office and the Department for Health and Social Care have produced Right Care, Right Person[189], a framework for local policy and health services to consider when determining their joint response to people in mental health crises. Local arrangements under this framework should be made clear to staff working in the ED.

The purpose of a section 136 is to facilitate assessment by a mental health practitioner and arrange necessary treatment. The assessment should happen within the first 24 hours, the timing of which commences on the arrival of the individual to the place of safety. According to RCPsych, a patient under a section 136 should be seen by an Approved Mental Health Practitioner (AMHP) and a doctor approved under section 12(2) of the MHA 1983 within 3 hours, unless there is a good clinical reason to delay[190,191.]

Continuity of care and transition to adult services

Young people often ‘fall through the gaps’ in mental health support, leading to increased visits to EDs during mental health crises. The age at which paediatric mental health care ends can vary, with some hospitals setting it at 16 years and others at 18 years, causing uncertainty around care thresholds. There is also often a gap for CYP when transitioning from CAMHS to Adult Mental Health Services (AMHS) in the UK, which occurs variably between 16 and 25 years of age[192]. The challenges of differing eligibility criteria and age cut-offs are compounded by various operational challenges such as unsuccessful referrals, lack of bed availability and poor liaison between CAMHS and AMHS, resulting in many CYP being left without access to mental health support. When transitioning from CAMHS to AMHS, the referral can be a lengthy process but should be managed effectively. The UK nations each have specific guidance on this process[193, 194].

When an adolescent patient presents to an ED with a mental health issue, there should be close collaboration with the mental health services that cover the hospital and community (for example, Liaison Psychiatry, CAMHS and AMHS) to ensure appropriate support and timely assessment[195]. The system should be designed to minimise unnecessary waiting times in the ED, short stay/observation units, or avoidable hospital admissions. Mental health services should be available 24/7, including weekends and bank holidays, to allow for continuous patient assessment.

Addressing these issues requires coordinated efforts and strategic planning to ensure young people receive the support they need during this critical transition period, so they do not end up presenting in a mental health crisis to ED.

CYP mental health hubs

Early support hubs aim to offer community-based, easily accessible mental health support for CYP between 11 and 25 years of age. These have been piloted in England and provide drop-in services for CYP to access mental health support, as well as support for wider issues including employment, housing and sexual health services[196]. Mental health hubs can prevent crises from escalating to the point where CYPs are presenting to ED with a mental health crisis by providing early intervention and support.

Standards

No.	Standards	Indicators	Evidence
37	All CYP presenting to the ED should have a developmentally appropriate assessment of their immediate emotional and mental health needs	• Evidence of guidance and training on conducting a developmentally appropriate assessment of a CYP's immediate emotional and mental health needs available to all ED staff who may carry these out	CQC. Assessing mental health in the emergency department. 2022
38	An assessment of immediate risk should be done for all CYP presenting in mental health crisis to inform decisions about where and how a CYP is treated within the ED, and this process should commence on arrival. This should include consideration as to how closely the CYP should be monitored and documentation of any safeguarding risks	• Use of a standardised electronic or paper platform with appropriate fields to record when a CYP is assessed on arrival to understand the level of immediate risk, and therefore judge the appropriate care pathway within the ED	RCEM. Mental Health Toolkit (Section 7). 2023 NICE. Guidelines: Self-harm: assessment, management and preventing recurrence (NG225). 2022
39	A safe and appropriate space must be available for CYP presenting in mental health crisis, which should accommodate parents and carers and allow suitable supervision by ED staff	• Evidence of a specific safe space for CYP in mental health crisis • Evidence of available reasonable adjustments	See Chapter 2: Environment in paediatric emergency care settings
40	ED staff must have access to mental health records and individual crisis care plans for CYP who present with mental health concerns or in mental health crisis via CAMHS liaison	• Evidence of policy on how to link with/refer to CAMHS liaison, including out of hours	RCPsych. Quality Standards for Liaison Psychiatry Services

41	A mental health practitioner should be available for telephone advice for CYP in the ED 24/7 and/or is able to attend the ED for direct patient assessment when required	• An appropriately staffed telephone number that is answered 24/7	NHS. Core 24 Standards RCEM. Mental Health in Emergency Departments. 2023
42	All CYP presenting to the ED following self-harm or in mental health crisis, must have a face-to-face developmentally appropriate biopsychosocial assessment of their immediate emotional and mental health needs within one hour of referral [vi], undertaken by a mental health professional from a paediatric liaison psychiatry/mental health crisis team experienced in carrying out such an assessment	• Guideline available to all ED staff • Evidence of this occurring (including recording presence of neurodivergence /learning disability) • Service level agreement in place between the ED and local mental health services	NHS England, Mental Health Clinically-Led Review of Standards. 2022
43	A clear system is in place with allied agencies to escalate the care of CYP who present with a mental health concern who • require Tier 3(+)/Tier 4 inpatient care, or • who do not require Tier 4 inpatient care but whose parent/carer feels unable to take them home	• Standard operating procedure in place for arranging Tier 3(+)/ Tier 4 inpatient care • Standing operating procedure in place for CYP whose parent/ carer feels unable to take them home, including relevant contact with social care services	NHS. Core 24 Standards
44	There is a clear pre-defined pathway for CYP on a section 136 order for an identified place of safety to meet their medical and mental health needs, as outlined in a local place of safety policy	• Operational policy in place • Evidence via case note audit	NHS LSCFT. What is a Section 136 of the Mental Health Act? RCEM, A brief guide to section 136 for Emergency Departments
45	ED staff receive training in how to communicate effectively, assess risk and immediately manage CYP with mental health needs and in supporting their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity/competence)*	• Local training programme and evidence of compliance	OHID. Trauma informed practice. 2022

46	ED guidelines are in place for the management of an acutely distressed or agitated CYP incorporating the use of de-escalation strategies, reasonable environmental adjustments and chemical/physical restraint for those who are at risk of harm to themselves or others	- Guidelines available to all staff and included in a training programme. - Documentation of rapid reviews following the use of physical or chemical restraint. - Evidence of audit of any use of physical or chemical restraint.	Mental Health Act. 1983. Department of Health (Northern Ireland). Regional policy on the use of restrictive practices in health and social care settings. 2023. NICE Guideline 10. Violence and aggression: short-term management in mental health, health and community settings. 2024.
47	When CYP require access to a mental health inpatient bed, but there is a delay of >4 hours, they should be looked after in a suitable paediatric clinical location with appropriate inpatient facilities, regular CAMHS reviews and physically present registered mental health and paediatric nurse support.	- Operational policy. - Case note audit. - Evidence of a clearly defined escalation process if there is a delay of >4 hours in locating a mental health inpatient bed.	NHS England. Supporting children and young people (CYP) with mental health needs in acute paediatric settings: A framework for systems. 2022.

* This includes the Mental health Act (1983, 2007); Children Act (1989, 2004); Mental Capacity Act 2005; Children and families Act 2014; and in Scotland, the Mental Health (Scotland) Act (2015), as well as other relevant national and local guidance.

Practice example

Practice example 1: Learning from Wakefield - ensuring CAMHS is the right pathway for CYP and preventing CYP from being hospitalised

Wakefield, part of the West Yorkshire Integrated Care Partnership, has been among the strongest performing areas across the metrics in Children's Commissioners Office (CCO) annual briefings[197]. It was the Clinical Commissioning Group (CCG)[vi] with the highest overall score in 2023.

For CYP with the most acute needs (including suicidal ideation, self-harm and a noticeable change in their mental health condition), Wakefield operates ReACH, which provides intensive treatment in the home to prevent CYP from requiring admission to inpatient mental health services. Most of the referrals come from EDs. The ReACH team aims to visit CYP in their homes, schools or other appropriate settings and assess their needs within four hours of the referral coming in, or within 24 hours for those who are based in the surrounding areas outside of Wakefield. To prevent a CYP's situation from re-escalating, the ReACH team provides intensive home therapy responsive to their level of need, ranging from a minimum of two contacts a week to three visits a day.

[vi] Based on NHSE data from the previous CCGs, noting the new ICB footprints do not map directly onto CCG areas.

Chapter 7: Children and young people with complex needs

For the purposes of this chapter, and the related standards of care, “children and young people (CYP) with complex needs” includes CYP with medical complexity and/or learning disability and/or those who are neurodivergent. Their complex needs may be related to the long-term effects of prematurity, inherited conditions, chronic illnesses, life-changing injuries, or life-limiting conditions. The range of conditions is not limited to, but can include, cerebral palsy or other movement disorders, epilepsy, autism (or other neurodivergent conditions), chromosomal and genetic conditions, chronic lung disease, complex metabolic disease, complicated cardiac disease, oncological conditions or organ transplants. All of these CYP, no matter their underlying diagnosis, have their own individual needs, challenges and strengths and, therefore a needs-based, rather than a diagnosis-based, approach is preferred to facilitate their emergency care.

CYP with complex medical and holistic care needs are likely to attend the Emergency Department (ED) more frequently. For example, some CYP are oxygen-dependent, have tracheostomies or salivary control difficulties and need regular suction. Some require enteral feeding, either via a nasogastric tube or a gastrostomy or jejunostomy. Polypharmacy with unfamiliar medications is not unusual. Technologies such as vagal nerve stimulators, deep brain stimulators, intrathecal baclofen pumps and communication devices are increasingly frequent, and palliative or advanced care plans may be in place.

CYP with a learning disability (also known as intellectual disability), even in the absence of additional health challenges, face significant barriers to accessing healthcare, potentially leading to health inequalities. When CYP with a learning disability present to the ED, care is needed to ensure that a holistic biopsychosocial approach is adopted. There should be specific consideration of the communication needs of this group, and an awareness of the difficulties they may face with sensory processing and diagnostic overshadowing: the process by which clinicians attribute specific signs and symptoms, including behavioural changes, to a patient’s underlying condition(s). Reasonable adjustments must be made for CYP with complex needs to ensure they receive equitable care[198] and this chapter sets out some that should be implemented in the ED.

Issues to consider

Systems should exist to identify CYP who have complex needs, so that staff are aware that extra help or resources may be needed. Ideally this would be an electronic flag on their medical record. However, some CYP with individual disabilities or complex medical needs may not be formally identified within the system, yet they may still require reasonable adjustments to support inclusion and access. Families and, where appropriate, CYP should be provided with the option to add electronic flags to their records regarding their specific needs.

Emergency care plans (ECPs)

Clinical and clerical ED staff should check whether the CYP has a documented individual ECP. Parents and carers may bring a copy with them, or it may be uploaded to the patient’s electronic medical record. Plans are especially useful for CYP with rare conditions, or who require specific medical management.

An ED attendance by a CYP with complex needs should be used as an opportunity to prompt the preparation of an ECP by the CYP's lead clinician, if one does not already exist. A plan empowers parents and carers to share information about the CYP's needs so that they quickly receive the most appropriate care. It may include details of both emergency management and other special personalised information regarding the patient, including contact details of the CYP's specialist team. The plan needs to be kept up to date and shared widely, not only within urgent and emergency care (UEC) settings, but also with the wider multidisciplinary professional team including therapists, specialist nurses, schools, respite care, general practice, community paediatrics, ambulance services and NHS 111 or NHS 24. Where possible, it should be uploaded to the CYP's electronic health record.

Health passports

Health passports differ from ECPs in that they contain general information about the CYP, rather than focusing on their medical needs. For example, a health passport should include how best to communicate with the CYP, what clinicians can do to make the CYP feel safe, and details of any specific sensory needs. Parents and carers may keep their child's health passport updated and might bring a copy with them. Where possible, it should also be uploaded to the CYP's electronic medical record. A flag can be added to signify that reasonable adjustments need to be made to ensure the individual has access to the same quality of healthcare as anyone else.

Access to hospital passports, reasonable adjustments and/or sensory resources must be based on individual need, rather than their diagnosis.

Who is with the CYP?

CYP may present with their parents or carers but may be accompanied by a school staff member. Parental responsibility needs to be clarified, and the identity of any accompanying adults confirmed. The lead clinician who has overall responsibility for care of the patient should be identified. Parents and carers may have had to repeat their complicated history on multiple occasions, and, over time, they will become an expert in their child's medical needs. Staff should always ask if they have information, such as an ECP, that will quickly help the clinician understand the medical background.

Do not assume that the CYP will be familiar with clinical environments and acknowledge that they may face challenges with sensory overload. During clinical assessment, try to demonstrate equipment and let the CYP become familiar with it. Where possible, leave distressing procedures until the end of your assessment, and ensure you use analgesia, topical anaesthetics and sedation where appropriate. Issues of consent and capacity may be relevant in CYP with complex needs, especially those over the age of 16 years[199,200, 201].

Communication

CYP with complex needs require the same privacy and dignity as any other CYP and providing a quiet private environment will help to minimise distress. Communication with CYP may be a challenge because of physical problems, speech and language differences, understanding or behaviour. Always ask the parent or carer if there is anything specific you need to know about how the CYP communicates and whether the CYP has a particular way of displaying pain or distress[202],[203]. The RCEM Learning Disability Toolkit[204] contains useful resources, educational materials and practical tips to consider when caring for patients with a learning disability. Communication and collaboration with parents and carers are key, particularly when CYP use non-verbal forms of communication. Consideration should be given to consent and decisions around capacity, with parents and carers similarly playing a key supporting role.

> ***"[Support] children with autism and global delay to process what is happening and help them to be able to desensitise going to hospital [...] having a learning disability nurse available to help them transition from Home to Hospital [...] and use all different types of communication for them to help them to understand what is going to happen [...] extra time to process and to have a better understanding of people with learning disabilities and complex needs"*** Young Person, RCPCH& Us 2025

Physical environment

EDs can be very stimulating for CYP with complex needs, particularly those with a learning disability or who are neurodivergent. This can result in distress and CYP may find it helpful to wait and subsequently be seen in a quiet space with a door, where it is calmer and less bright. Where possible, noisy equipment should be minimised and tools such as ear defenders can be useful.

A number of other adjustments to the ED environment are important for this group, and further information can be found in Chapter 2: Environment in paediatric emergency care settings.

Systematic assessment and knowing what is usual for the CYP

Emergency assessment needs to be a systematic process, as for any other sick CYP. Consider how this can be achieved safely and adequately; for example, moving a CYP out of a wheelchair to facilitate examination needs to be done without causing avoidable distress. Some CYP with complex needs have different anatomy and physiology; understanding their baseline is important in evaluating the significance of clinical observations. For example, some can present as relatively hypothermic when well, meaning that a "normal" temperature may be relatively high. Different equipment may be needed, for example various hoists, and it may take some time for a CYP to feel familiar enough with ED staff and surroundings so that an objective examination is then possible.

CYP with complex needs may display pain in different ways and require different methods of pain assessment. Consider non-verbal cues that a CYP may be in pain, including posture, facial expression and sounds made, as well as using parents or carers who may be able to identify more subtle signs that suggest their child is in pain. These are encompassed in different pain scales, such as the Face, Legs, Activity, Cry, Consolability (FLACC) scale[205, 206], or by using different symbols/pictures that some CYP with complex needs may find easier to use.

Parents and carers often notice changes indicating illness earlier than health professionals. This is at least, in part, due to the recognition of "soft signs". These vary for each CYP and might include things like not wanting to eat a favourite food, being paler than usual, or not wanting to watch a favourite TV show. It's important to acknowledge these soft signs as clinical indicators of ill health and to consider the possible underlying causes. Always listen carefully to the views of their parents and carers, who know their child best and can best identify what is not usual for them. The concerns of a worried parent or carer should always be thoroughly explored.

Diagnostic overshadowing

CYP with complex needs, especially those who are autistic or have a learning disability, can often be subject to diagnostic overshadowing. Care is needed to ensure clinicians have a good picture of what a patient is like when they are well, and that parental or carer concerns are taken seriously. Alternative diagnoses should always be sought for changes in behaviour, for example, pain, injury or infection. Baseline physiology can be different in CYP with complex needs, and correlation with care plans and reports from parents and carers is crucial to work out what is normal/abnormal for a particular CYP and not just assumed to be a consequence of their additional needs.

CYP with complex needs are often at increased risk of infection, and child abuse (see Safeguarding sub-section on this page below), and there is recognised morbidity associated with both. CYP with complex needs should have early escalation for a senior opinion to ensure diagnostic accuracy of their presenting complaint(s)[198].

New behaviours such as agitation can be a sign of pain or illness and a thorough examination and investigations are likely to be required. Calming and de-escalation should be tried in the first instance to facilitate this. However, if despite these measures, the CYP remains very agitated, restraint and/or sedation may be required. This should be done in the least restrictive way possible, using clear protocols and by staff who are appropriately trained. Parents and carers should be involved in any discussions about such a step.

Weight, drugs and nutrition

CYP with long-term conditions may be underweight, or overweight compared to the general population. This may be important for accurate drug prescribing and clinicians must consider whether age-based prescribing is appropriate, and should take into account weight and body habitus, for example those whose weight is <0.4th centile or >99.6th centile.

The British National Formulary for Children (BNFC) standardised dose based on age, weight, and/or body surface area should be used for electronic prescribing. Where medicine administration systems are used to calculate paediatric dosages, these must be checked by an appropriate clinician.

These CYP often require multiple medications, some of which will not be commonly used in EDs, and an awareness of potential drug interactions is important, along with consideration of antibiotic resistance. CYP with complex needs may have poor nutritional status and unusual physiology. These CYP, particularly those with severe dystonia presenting in status dystonicus, are at risk of rapid dehydration.

Transition to adult services

Emergency attendances by CYP with complex needs must be considered during planning for the transition of care to adult services, and there must be discussion of the most appropriate UEC setting for the CYP's developmental needs. Agreement should be reached between paediatric and adult ED services, together with the CYP and their parents or carers, on where the emergency care needs of the young person will be best met as they transition between services, including the most appropriate services for onward referral when required.

Safeguarding

CYP with complex needs have the right to the same protection and standard of care as any other child. Special attention should be paid to the CYP's communication support needs. CYP with limited or no mobility are likely to be osteopenic and may sustain fractures with minimal force, and careful judgement is needed in making safeguarding decisions. Unfortunately, CYP with complex needs are at increased risk of abuse.

Attendances to UEC settings must be communicated with the other agencies involved in the CYP's care, including social workers and the primary care team.

Longer term follow-up and care

CYP with complex needs often have multiple appointments with numerous professionals. UEC may occur some distance from home. Ensure the lead clinician is aware of any emergency attendances when there has been a change or new concern, e.g. increased seizure frequency.

End-of-life planning for CYP with life-limiting conditions

Decisions regarding end-of-life care are complex, require consultant-level decision making and are best planned in advance. CYP towards the end of their lives may have a documented advanced care plan or ‘wishes document’ and ideally a lead clinician/palliative care team will have worked with the CYP and their family to think about what management is appropriate in these circumstances.

These CYP can present unexpectedly in extremis and will require sensible decision making, particularly around starting or stopping resuscitation. The CYP, parents, carers and families should be at the centre of this decision making and will often want honest and open communication, acknowledging how difficult the situation is.

Sometimes the CYP may present with a potentially reversible cause for their acute symptoms. Clinicians should be aware of the potential for unconscious bias to withhold a treatment or investigation because of the palliative nature of a patient, or because of judgements made about quality of life. Quality of life is individual and complex and best considered outside of the UEC setting, alongside the CYP and family and their specialist MDT. Many CYP with severe disabilities can participate in enjoyable activities and have a meaningful community and social life[207].

Staff training/workforce

All ED staff should have formal training around the adjustments that should be made for CYP presenting with complex needs, including how to weigh and measure, take observations and in assessment and communication techniques. Staff should be encouraged to undergo formal Oliver McGowan Mandatory Training on Learning Disability and Autism[208]. The Learning Disability Liaison Nurse should work closely with the ED team to deliver training, as well as to help facilitate difficult clinical situations when possible. A play specialist is also an essential asset for any ED, but particularly for CYP with complex needs.

Standards

No.	Standards	Indicators	Evidence
48	There should be systems in place in the ED to identify/flag CYP with complex needs. ED staff should ask to see the CYP’s ECP, where one exists, which should be held electronically wherever possible to signpost to relevant information, such as the possible requirement for early senior assessment or the need for reasonable adjustments. Systems should be in place to enable CYP with complex needs to be prioritised, following a needs-based approach, when seen in the ED	• Evidence that alerts are used to signpost to ECPs, where these exist • Evidence of the use of a triage or early warning system which identifies CYP with complex needs when allocating priority. • Evidence that updated ECPs are easily and readily available in the ED, with systems in place for communicating and passing responsibility to a patients’ lead clinician or team to upload, review and update ECPs as required	NCMD. 2024. Learning from deaths: Children with a learning disability and autistic children aged 4 - 17 years

49	When treating a CYP with complex needs in the ED, systems should be in place to enable escalation for review by a senior decision maker	• Evidence of clear escalation pathways mentioning CYP with complex needs and inclusion within training and induction packages	N/A
50	EDs should have accessible information and communication tools available for CYP with complex needs and/or communication differences including, but not limited to, pain assessment tools, access to an interpreter (including for sign language) and visual aids such as social stories and easy-read information leaflets	• Compliance with Accessible Information Standards. • Evidence of pathways for referral to interpretation services, including sign language • Evidence of availability of visual communication aids	Communicating with Children The revised FLACC observational pain tool: improved reliability and validity for pain assessment in children with cognitive impairment Reliability of the Faces, Legs, Activity, Cry, and Consolability Scale in Assessing Acute Pain in the Pediatric Emergency Department NHS England. Accessible Information Standards
51	EDs should have a lead professional for CYP with complex needs and access to advice and support from a Learning Disability Liaison Nurse	• Evidence of a lead professional (medical or nursing) for learning disability within the department to maintain an overview of departmental training, the development of pathways and policies and provision of care, with allocated time in their job plan • Evidence of links with a Learning Disability Liaison Nurse	N/A
52	ED staff must have appropriate training in the management of CYP with complex needs	• Evidence of completion of training, including Oliver McGowan Mandatory Training and specific training relating to access to UEC	The Oliver McGowan Mandatory Training
53	Information about a CYP with complex needs attending ED should be shared with the relevant professionals involved, including the GP and lead clinician, where one exists. Links should also be established with the community children's nursing team to ensure effective follow-up care and support	• Evidence of systems to ensure information sharing with GPs and other relevant professionals	N/A

Practice examples

Practice example 1: Sheffield Children's Foundation NHS Trust: Managing CYP with complex needs in the ED

The ED at Sheffield Children's Foundation NHS Trust[209] has developed a guideline for medical and nursing staff involved in assessing and managing children with complex needs. Families are encouraged to identify complex needs when booking into the department, and digital flags that highlight the need for reasonable adjustments and the increased risk of serious illness are added to electronic patient records.

A "quiet room" is provided for families to wait and where the CYP can be assessed. This room provides minimal auditory and visual stimulation for CYP who may otherwise be subject to sensory overwhelm. When this room is already in use, other areas of the department are adapted for similar use if needed, and ear defenders are available. Other equipment is available for CYP who may benefit from sensory stimulation or distraction.

Communication resources including pain assessment tools, "now and next" boards and easy-read descriptions of common investigations and treatments are available, and some ED staff members (including reception staff) have undergone training in Makaton.

All staff attend mandatory training on learning disability and autism, and ED-specific training is provided by the ED learning disability team. This team comprises medical and nursing staff who are part of a wider team of learning disability ambassadors sharing best practice across SCHFT, working closely with the Sheffield Children's Lead Learning Disability Nurse to provide updates to colleagues and lead on quality improvement and peer supervision within the ED.

ED staff have worked with CYP and their parents and carers to identify areas of care delivery which can be improved upon. For CYP with complex needs who regularly attend the ED, emergency care pathways are drawn up in conversation with the patient and family, and with MDT input including learning disability nursing, community teams, specialty teams and social care. ED staff are encouraged to listen to the concerns of parents and carers, and to acknowledge them as experts in their child's health and wellbeing.

Practice example 2: Managing CYP with medical complexity and communication needs in the ED

Kayden is an 8-year-old with cerebral palsy with a Gross Motor Functional Classification Scale of 5. He has complex epilepsy, recurrent chest infections and dystonia. He is PEG fed, non-verbal but can understand Makaton, and mobilises in a wheelchair.

He usually presents to his local hospital either due to increase in seizures or because of a lower respiratory tract infection.

He has a bespoke emergency care plan for his seizures which sits in his electronic medical record. His mother has completed a hospital passport for him, which reminds staff that he uses Makaton and that he needs to be in his own quiet space. His mother usually brings his ear defenders with her, but the passport reminds the team that he will get quite anxious in a hyperstimulating environment. He is usually bradycardic and hypothermic and therefore 'normal' ranges would be abnormal for him, which is also in his passport.

His mother has found the passport very helpful, as it saves her having to continually repeat herself and seem like she is challenging ED staff - it gives her a simple way of advocating for Kayden.

At present his mother will do much of the lifting of Kayden from his wheelchair onto a bed. He is underweight (16.5kg) and therefore it is important that the team give weight-based drugs rather than age-based.

Chapter 8: Health improvement and health inequalities

Health inequalities are the avoidable, unfair and systematic differences in health between different groups of people. These groups may be defined by various factors including gender, ethnicity, geography, sexual orientation or income. Grouping people by their income reveals a significant difference in health outcomes between the poorest and richest in society, even in early childhood, and these inequalities often persist into adulthood[210]. Children and young people (CYP) in the UK have some of the worst health outcomes in Europe[211], with high infant mortality rates[212] and the inequalities in health experienced by different groups underlies this.

The Emergency Department (ED) is one of the health care settings where these inequalities are most evident. CYP from the most deprived backgrounds are 58% more likely to attend the ED than the least deprived, and 55% more likely to have an unplanned hospital admission[213]. There are several reasons for this, many of which are unrelated to a CYP's state of health. Families living in areas of socioeconomic deprivation do not have the same access to primary health care as those living in wealthier areas. GPs in the most deprived areas care for, on average, 300 more patients per head of population than their colleagues in less deprived areas[214], despite the fact that these patients often have greater health needs. In addition, a high prevalence of caring responsibilities and insecure employment (where it can be difficult to take a day off work for a medical appointment[215]) in more deprived areas, acts a further push towards parents seeking urgent out-of-hours care. CYP living in deprivation are also more likely to have a health need which the ED is most suited to meet, as they are more likely to experience trauma[216], head injuries[217] and acute emergencies[218].

Healthcare professionals continue to be one of the most trusted sources of health information, and there is evidence to suggest that providing public health interventions can increase patient satisfaction in the ED[219]. So, it is an ideal setting to empower CYP and their families with relevant health promotion information.

The consultation

In every consultation any precipitating factors should be considered. Was the cyclist who was hit by a car wearing a helmet? Is there a way to make a family's home safer after an accident where a child has fallen down the stairs or out of a window? Does the CYP presenting in diabetic ketoacidosis (DKA) need a review with the diabetes nurse? All these interventions could prevent ill health in the future. Other things to consider include:

- **Interpreter services:** All EDs should have access to interpreter services 24/7. This ensures health concerns can be properly identified, practitioners can be confident that communication is clear, and advice can be taken on board. Where possible, avoid the use of family members as interpreters, especially when discussing concerns around safeguarding.
- **Professional curiosity:** Follow up on everything brought up in a conversation. Sometimes a CYP, parent or carer may mention something not related to the current presentation, such as a mental health concern. This should always be addressed and, if possible, the family should be signposted to appropriate support.
- **Chronic disease:** Many CYP with chronic disease attend the ED when their condition necessitates. Providing good advice, in collaboration with their specialty teams, can reduce future attendances, for example advice on reducing exposure to air pollution in asthmatics, reviewing inhaler technique and addressing smoking cessation with parents.

- **Violence reduction:** All departments should have access to a service to which they can refer young people who have presented because of violence, either as victim or perpetrator. 16% of 13–17-year-olds surveyed in 2023 had been a victim of violence in the previous 12 months [220]. Emerging evidence suggests that having a Youth Navigator team available in the ED to provide holistic support to young people will reduce the risk of further violence[221] (See more information in Chapter 3: Workforce and training – youth workers embedded within the MDT and Chapter 5: Safeguarding in emergency care settings). There is often a socioeconomic gradient to involvement in violence, and Youth or Family Navigators have a role in supporting the whole family across a wide range of other areas such as accessing food banks, community involvement and advice on benefits.
- **Safety netting:** Good safety netting is not just about preventing reattendances, it is also about ensuring families have the right information about what to do if their child becomes more unwell. CYP and their parents/carers must be provided with both verbal and written safety netting information at the time of ED discharge, in a form that is accessible and in a language they can understand. This should include where and when to seek further medical advice. There are a number of helpful resources about common childhood conditions available, including the Healthier Together Website[222]. This can be used in both primary and secondary care and helps ensure consistency of messaging from all health professionals, which in turn will increase parental confidence in managing simple conditions at home. See further information on safe discharge from emergency care settings in Chapter 4: Management of the sick or injured child.
- **Reasonable adjustments:** Reasonable adjustments should be made for those CYP with complex needs. See Chapter 7: Children and young people with complex needs for more information.

Common public health issues

1. **Disordered eating:** During a face-to-face consultation in the ED there is the potential opportunity to identify other health issues that might not otherwise have been picked up: Rates of disordered eating in the general population have been a developing public health crisis for some time[223]. 30% of the most deprived children are already obese by Year 6 at school, a number which is increasing, compared with about 13% of the least deprived, a number which is falling. This gap is continuing to widen (see Figure 1). A brief discussion about weight accompanied by signposting to appropriate support may make a difference.

   At the other end of the weight spectrum, rates of eating disorders have also increased significantly[224] and early intervention is essential. A Body Mass Index (BMI) should be calculated for those patients where there is a concern and, if there is an issue, discussed with the family in a sensitive trauma-informed manner, with signposting to relevant services and online support such as the NHS Eat Well resources and Healthy Start scheme.

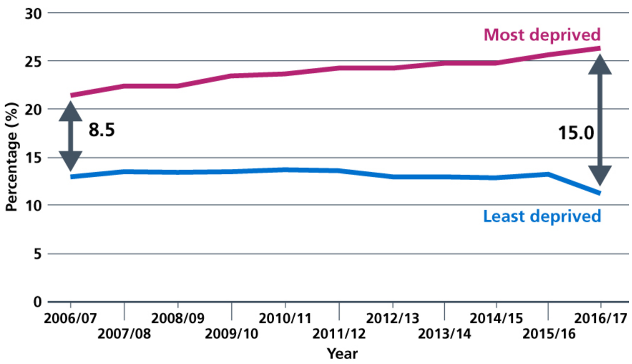
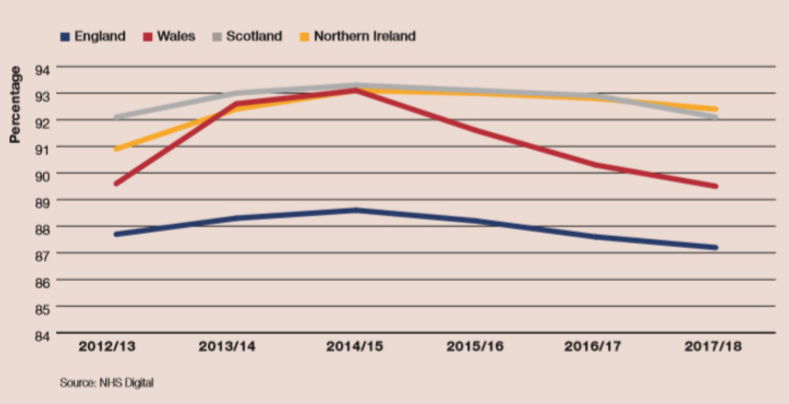


Figure 1: Childhood Obesity at Year 6 of Primary School

2. **Dental health:** Those living in more deprived areas are less likely to visit a dentist, unless they are experiencing symptoms[225]. Tooth decay continues to be one of the biggest reasons for the elective admission of children to hospital for surgery. Being able to give brief advice about dental hygiene and support on how to access a dentist is important.
3. **Vaccinations:** Rates of vaccine uptake have been falling for several years, pre-dating the COVID-19 pandemic. This has contributed to recent outbreaks of measles and pertussis with associated morbidity and mortality. This is due to vaccine hesitancy and barriers to access. Work by the Royal Society for Public Health showed that these barriers are significant and include the timing and availability of appointments, and the impact of other childcare duties[226]. Making a strong recommendation, reminding parents, asking about any concerns and being able to talk confidently about vaccines, may result in some children being vaccinated who would previously have not[227]. Families can also be directed to information resources such as the Oxford Vaccine Knowledge Project[228]. Including that vaccines are not up to date in the discharge letter to the primary care team can also flag this as an issue for a particular CYP.



Source: NHS Digital

Figure 2: Percentage of children who receive both MMR doses by their fifth birthday

4. **Under 1s:** This is a vulnerable age and there are resources that new parents can be directed to, improving their parenting knowledge and preventing morbidity and mortality further down the line. Safe sleeping advice, such as from the Lullaby Trust[229], can help to prevent SIDS. Excessive crying can be a high-risk situation for babies and parents, and signposting to the ICON advice on how to cope[230] may reduce the risk of NAI.
5. **Smoking and vaping:** The harms of tobacco smoking are well known: tobacco has led to millions of deaths and is a significant cause of morbidity. Vaping is on the rise amongst young people with most having never smoked a cigarette, but the harms of vaping are not fully understood. There are concerns regarding acute toxicity, especially when misused, exacerbation of respiratory conditions and the high usage amongst CYP acting as a gateway to nicotine addiction and cigarette usage[231]. A brief enquiry and signposting to local services may help a young person stop smoking or vaping.

Screening

EDs should take a proactive approach to screening CYP. Examples of relevant issues to screen for include mental health concerns, drug or alcohol abuse, sexual health concerns or involvement in violence. A common barrier to undertaking this kind of activity is time. ED attendances are increasing year on year, and there is a constant pressure to see and discharge patients in a timely manner. However, the screening does not necessarily need to take place during the consultation. A screening tool can be used during the time a young person spends waiting to be seen. A biopsychosocial assessment tool such as HEEADSSS, or Not Just a Thought, can be completed via a web-based app[232] where the young person can access via a QR code, answer questions independently and be signposted to useful resources and community organisations. The team behind the HEEADSSS tool found that 98% of young people preferred to use the tool without a healthcare professional present, either completing it by themselves or with a parent[233]. With this in mind, the needs of those with lower reading levels should be considered when structuring the text in these tools.

Children and young people seeking asylum and refugees (CYPSAR)

CYPSAR are entitled to the same healthcare as UK nationals. If they have recently arrived in the country, they may not be familiar with the UK healthcare system or how to access it. The Refugee Council has leaflets in a variety of languages which explain how to access services[234]. They should all be encouraged to register with a GP if they haven't yet done so. All communication should be done with an appropriate interpreter, and their name spelling, date of birth and address should be confirmed. At the start of the consultation the principles of confidentiality should be explained, as well as the fact that the health service and medical records have no connection with the Home Office. Always give families any letters in written format so that information can be easily shared with other healthcare professionals.

These families will have a variety of health concerns. Each locality should have a process for assessing the health and needs of these families, and each ED should have a guideline on how families can access this system. This will likely include referral to early help, social services and other relevant specialties if any chronic health or developmental needs are identified, or if the family is struggling to integrate, for example, with children not in school. Unaccompanied young people are looked after children and should already have a named social worker and had a health assessment in the community. Those CYPSAR who are accompanied by family members will not have this by default.

See Chapter 5: Safeguarding in emergency care settings and the RCPCH guidance on CYPSAR for further information[235].

Socioeconomic determinants of health

"Why treat people and send them back to the conditions that made them sick?" [236]
Sir Michael Marmot

It has been estimated that healthcare services are only responsible for approximately 20% of health outcomes whilst behaviours such as drinking, smoking and diet account for 30%. This means that 50% are due to socioeconomic circumstances and the built environment in which the family are living[237]. There are 4.3 million CYP currently living in poverty[238] in the UK. That is 9 in every class of 30. 70% of those are in a household where at least one parent is working. 44% are in lone parent families and 47% are from Black and Minority Ethnic groups[238]. This is without a doubt impacting their health.

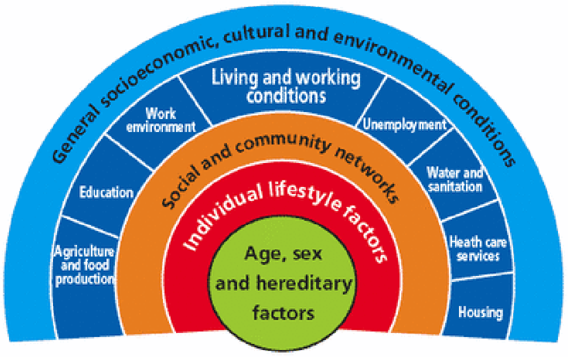


Figure 3: The Determinants of Health

This diagram demonstrates the complex environment in which a child grows and all the different elements that will impact their health.

If we examine why obesity is more prevalent in deprived communities for example, we can point to the fact that healthy food is often more expensive and harder to access. Mental health is a significant factor in losing weight and those living in deprivation have a higher risk of poor mental health. Housing is more concentrated with less green spaces and less safe neighbourhoods, so outdoor play is harder. A lot of after school activities are too costly for many families.

Those working in EDs should be able to discuss these issues sensitively, in a trauma-informed way and signpost families who are struggling financially to organisations such as the Citizen's Advice Bureau or Shelter. Some departments are introducing Family Navigators or support workers for exactly this reason.

Looking more holistically at the wider family can support the CYP in the short term and helps them in the long term, for example by providing parents with ways they can become more involved in their community[239,240], such as parent and baby groups. Departments should have resources to support parental mental health, and there should also be policies and systems for the identification of domestic violence. Living in a home where there is domestic violence is a cause of significant trauma in childhood, which can have an impact on long-term health outcomes. See Chapter 5: Safeguarding in emergency care settings for further information.

The organisation Wellbeing and Health Action Movement[241] has a variety of ideas and practical activities on their website that can help reduce the impact of these social determinants of health. CYP with complex needs also have poorer health outcomes. Please see Chapter 7: Children and young people with complex needs for more information on how EDs can best provide for this group.

> ***"I think that there should be more universally accessible and collaborative achievable healthcare which isn't discriminatory or harmful in any way shape or form"*** Young Person, RCPCH& Us 2025

Standards

No.	Standards	Indicators	Evidence
54	All EDs treating CYP should have resources and signposting for common public health issues, such as maintaining a healthy weight, oral health, vaccines and immunisation information (including targeting vaccine hesitancy) with any health promotion advice documented in the patient's notes	• Evidence of available relevant printed and digital materials and guidance for ED staff on how to use and distribute these resources	Scotland: Emergency Department Guidance Signposting/ Redirection: Best Practice Guidance (Update)
55	All EDs should provide relevant information on benefits and support for families who may be struggling financially	• Evidence of available printed and digital materials or availability of family support service/workers	N/A

56	All young people of secondary school age should undertake a biopsychosocial assessment in the ED (e.g. HEEADSSS or Not Just a Thought) with signposting to relevant resources including smoking, drugs, alcohol and sexual and mental health advice	- Completed HEEADSSS/other assessments in patient records - Evidence of ED staff training on conducting biopsychosocial assessments - Provision of signposting to relevant support and information resources	NHS England » Urgent and emergency mental health care for children and young people: national implementation guidance RCEM, Management of Adolescent/Young Adult (AYA) Patients in the Emergency Department
57	All EDs treating CYP should be able to refer relevant patients to a violence reduction service	- Evidence of ED staff training on identifying and referring cases of violence - Availability of contact information for violence reduction services	NHSE, 2022, In-Hospital Violence Reduction Services: A Guide to Effective Implementation
58	All EDs treating CYP should identify a lead professional for health promotion and public health, with dedicated time in their job plan, and health promotion and public health issues should be included in a department's teaching programme	- Appointment of a lead health professional (medical or nursing) for health promotion - Records of health promotion initiatives from the lead - Curriculum showing inclusion of health promotion and public health topics	RCEM: Improving Public Health and Reducing Health Inequalities in Emergency Departments RCEM Position Statement On Public Health In Emergency Medicine Rcem Special Interest Group
59	All EDs should have 24/7 access to interpreter services, including a BSL interpreter	- Contracts or agreements with interpreter service providers. - Guidance for ED staff on how to access and use interpreter services	NHS England » Improvement framework: community language translation and interpreting services Interpreting, communication support and translation national policy
60	All EDs should have a guideline and pathway for CYPSAR (whether accompanied or unaccompanied)	- Evidence of written guidelines on how CYPSAR should be managed in the ED with consideration given to any additional screening they may need - Evidence of ED staff training on these guidelines and pathways	Children and young people seeking asylum and refugees - guidance for paediatricians | RCPCH
61	All EDs treating CYP should have access to written and electronic safety netting advice for common paediatric presentations in accessible formats and in a variety of languages. Safety netting advice given should be documented in the patient's notes	- Availability of safety netting advice materials in multiple formats and languages - Record of ED staff training on providing safety netting advice	NHS Healthier Together

Practice examples

Practice example 1: HEEADSSS web-based app

The HEEADSSS assessment is a biopsychosocial risk assessment tool for young people. When used appropriately, it can identify relevant risk and protective factors related to adolescent health and wellbeing, ensuring treatment follows a biopsychosocial model of care. The ED often serves as the first point of contact for some vulnerable adolescents in crisis, and the use of HEEADSSS can provide access to a range of resources that could support the young person's health and wellbeing. Raising awareness of HEEADSSS among ED staff is crucial for its proper use and it can directly impact the quality of patient-specific management plans.

The HEEADSSS assessment tool has been effectively used in UEC settings to improve the quality of care for adolescents. At Southampton Children's Hospital[242], the app allowed adolescents to complete the assessment themselves, which was well-received; the majority of adolescents (74%) preferring to use the app independently, rather than discussing the issues with a healthcare professional. Most adolescents found the app easy to use (98%) and helpful in identifying resources (82%). The use of the self-screening app helped address time and resource barriers faced by healthcare staff in EDs. It facilitated a biopsychosocial approach to care, which is crucial for effective treatment of adolescent patients.

Practice example 2: Not Just a Thought…

Funded by NHS England (North), the University of Salford and partner NHS organisations developed a communication resource called "Not Just a Thought…". The 'Not Just a Thought…' communication model was co-produced with 75 CYP who worked with professionals from the NHS, social care, education, police and charities. A model was created to support practitioners and CYP to work together, to share their thoughts and reduce the risk of abuse and other harms in a CYP's life. The resources that were created are freely available via an open-access website which uses CYP-friendly language. Specific toolkits are available including:

- Starting a conversation
- Core questions
- Learning & engagement
- Downloads & resources

The Not Just a Thought… resources were re-launched in March 2024 and are available at:
https://www.salford.ac.uk/news/not-just-a-thought-child-protection-campaign-relaunches

The Not Just a Thought… model has been tested with young people and professionals and it was found that the model allowed young people to feel more at ease with this type of difficult discussion, offering the opportunity to divulge sensitive information or a troubling issue, rather than demanding information. Furthermore, the professionals felt better empowered to enter into discussions on sensitive topics. They found the model easy to apply with minimal preparation and felt the conversation was safe and enabling. The professionals wished to see it adopted into practice. They were clear that more experienced staff would probably incorporate the model into their existing practice fairly seamlessly, but that the greatest impact would be on the practice of less experienced workers. For those with less training and little experience of addressing these challenging issues with young people, the model would provide structure and confidence. The physical context of the encounter became less important, if the professional approach was right. https://salford-repository.worktribe.com/output/1347257/testing-the-not-just-a-thought-model-with-young-people-and-professionals

Further information:

https://hub.salford.ac.uk/applied-health-research/equity-inequalities-and-inclusivity/not-just-a-thought/

Peach D, Rowland AG, Bates D, et al. 2018. Not Just a Thought... The University of Salford (UK), St Anne's High School, Stockport, The Pennine Acute Hospitals NHS Trust & NHS England (North). ISBN: 978-1-912337-06-4.

Long, T. 2017. Testing the Not Just a Thought model with young people and professionals. Salford (UK): The University of Salford

Contact: Dr Donna Peach, The University of Salford: D.Peach@salford.ac.uk

Chapter 9: Major incidents involving children and young people

Emergency preparedness

The NHS needs to plan for, and respond to, a wide range of incidents that could affect health or patient care. Previous major incident planning that focused on large scale trauma has had to evolve. Planning now includes Hazardous Materials (HAZMAT) and Chemical Biological Radiological and Nuclear (CBRN) events, infectious diseases and being alert for emerging threats that may challenge service continuity. Not all incidents are unexpected catastrophic 'big bang' events with sudden impact multiple casualties; there is recognition of rising tide major incidents such as pandemic influenza or COVID-19, with lead times of days or weeks to months. Some may be "cloud on the horizon" events, such as a chemical release or extreme weather events needing preparatory action. All of these must inform major incident planning for children and young people (CYP).

Under the Civil Contingencies Act 2004 and the Health and Care Act 2022[243] , all NHS organisations have a duty to put in place business continuity arrangements to identify and manage risks that could disrupt normal services. The UK Health Security Agency (UKHSA), the NHS for each of the four nations, and local authorities have a responsibility to work together to develop and maintain effective health planning arrangements for potential major incidents. NHS England's (NHSE) Emergency Preparedness Resilience and Response (EPRR) Framework[244] emphasises a whole-system approach to maintaining service continuity during an emergency, ensuring that all parts of the patient care pathway are considered and aligned. Guidance is available in each UK nation that sets out the requirements for planning preparedness, resilience and response to potential threats[245,246,247,248].

COVID-19 highlighted the need for formal pandemic planning. It is crucial there is representation from Emergency Departments (EDs) on pandemic planning groups to inform on the impact and potential challenges at the front door and to ensure that the safety and interests of all patients, including CYP and clinically vulnerable groups, are considered.

CYP have specific vulnerabilities in emergency and disaster situations, with unique physiological and psychological responses. It is imperative that emergency planning protocols and training include a sufficient focus on CYP to enable organisations to effectively respond to any surge of paediatric presentations during a major incident.

Preparation

Roles and responsibilities

EPRR roles and responsibilities fall on various national, regional and local partners to adequately plan and prepare for an emergency. NHSE has developed guidance to assist with escalation and de-escalation during an incident, with the highest level (4), resulting in management by UK Central government[249]. NHSE Concept of Operations for managing mass casualties[250] outlines NHSE arrangements for the response to mass casualty incidents and the organisation's requirements. The other UK nations have corresponding national emergency planning frameworks[245, 246, 247, 248].

EPRR planning and local health resilience partnerships

Across the UK nations, EPRR planning systems are in place to meet known and emerging threats and take an all-hazards approach to cover unknown or unanticipated threats. These will also take into account the diverse health needs of local communities.

- In England, Integrated Care Systems and Integrated Care Boards monitor providers' compliance with EPRR obligations and core standards, leading the local assurance process as NHS system leads[251]. Regions will provide a regional EPRR assurance report to the national EPRR, which will submit an annual national EPRR report to the NHSE Board[252].
- NHS Wales has an annual review assurance process for EPRR, whereby providers must submit annual Emergency Planning Reports[253].
- In Scotland, Resilience Committees report to Health Boards on emergency preparedness, training, exercises, resourcing and any gaps in capability or capacity; reporting should be regular and at least annually[247].
- In Northern Ireland (NI), the NI Hub coordinates activities across departments and agencies, reporting and analysing information through the NI Situation Report to the NI Executive and Civil Contingencies Group and sharing it with Departmental Operation Centres on a common platform[254]

Local Health Resilience Partnerships (LHRP) provide strategic forums for joint EPRR planning across a specific geographical area and facilitate health sector preparedness and planning for emergencies through the Local Resilience Forum (LRF).

Major incident planning

Preparation should include:

- Plans for a coordinated health response including suitable command and coordination arrangements for the health sector
- Provision for scaling and mutual aid
- Provision for exercising of major incident plans
- A framework to ensure that all plans are current and effective, for example involving an annual review and update

All hospitals should have a written major incident plan. The use of action cards within a major incident plan can reduce the cognitive load for all professionals with roles in the response to any major incident.

CYP must be specifically considered at a strategic planning level for major incidents, and in hospital-wide planning, including EDs, for training in regard of patient triage, stabilisation and disposition.

Some areas of planning required specifically for CYP include:

- Managing directly affected paediatric patients[255]:
  - Triage - an understanding of age specific physiological variables, as using adult triage parameters will over triage CYP and overwhelm the system, whilst under-triage will lead to increased morbidity and mortality. This is an area of ongoing development with most current triage tools[256] designed for pre-hospital triage[257]. NHSE has published clinical guidelines on ED paediatric triage for major incidents and mass casualty events[258].
  - Paediatric specific skills.

  - Paediatric specific equipment.
  - Familiarity with, and understanding the challenges of using, personal protective equipment when managing CYP.

- Capacity of the ED and/or other services to deal with large numbers of CYP of varying or similar ages:
  - Numbers and availability of paediatric trained staff.
  - Multiple CYP presenting with particular paediatric health care needs.
  - Safeguarding and care of unaccompanied and potentially unidentified CYP.
  - Prioritising keeping affected families, including adults, CYP and siblings together who are involved in the same incident.
  - The ability to clear the ED of non-incident patients and provide alternative areas for their safe assessment and management.
  - Supervised overflow areas for non-admitted CYP, as well as reunion areas when patients are deemed medically fit for discharge.
  - CYP not directly affected by the incident, but who present with concerns about exposure to infective or CBRN agents.

- Networking with other healthcare organisations to provide cohesive services:
  - Networked protocols and training with pre-hospital agencies.
  - Availability of specialist units (e.g. paediatric burns or paediatric intensive care beds).
  - Provision of psychological support to CYP, families and staff involved in the incident.

- Mental health support:
  - Prompt notification of the CYP’s GP, health visitor or school nurse of the treatment a CYP has undergone in response to a major incident will enable these services to provide extra support as needed.
  - Trauma-focused cognitive behaviour therapy should be offered to older CYP with severe symptoms of PTSD that persist for longer than a month[259].
  - Debriefing CYP immediately after such an event can be unhelpful and it is important that emergency care staff do not make uninformed assumptions about the range of emotional behaviours CYP may exhibit in response to an event.
  - CYP admitted following a major incident can have their case discussed with the hospital psychology team following consultation with the CYP and their family/carers.

Major incident exercises

To date, major incident exercises have primarily been in the form of tabletop exercises where a theoretical scenario is discussed and managed, with all the key multidisciplinary personnel who would play a role in the major incident response present. Exercises should be designed to test the major incident plan and, in doing so, may expose vulnerabilities in an organisation’s structure, systems or processes[260]. This should initiate changes to strengthen the plan. Exercises also aim to review both internal and external communication and improve management decision making during an incident. They are used to assess and identify gaps in competencies and if any further training is required for staff.

Coordinated multi-hospital and multi-agency training exercises may help health care facilities prepare for paediatric disaster victims and mass casualty incidents.

Translational in-situ simulation provides an additional means of testing aspects of a major incident plan. Simulation training allows the practice of both the technical and non-technical skills required to manage a major incident and should involve the entire multidisciplinary team.

Incident exercises involving CYP can be rewarding, providing important opportunities to enhance preparedness. However careful consideration must be given to ensure:

- The health and safety of CYP is paramount; for example, providing a safe environment and protecting CYP from extremes of temperature.
- Safeguarding advice has been sought.
- The privacy of CYP is respected.
- The CYP taking part are valued, encouraging qualitative and quantitative feedback.

Adolescents and young people

The content of this chapter is applicable to adolescents. Special consideration will need to be given to mutual aid, including between medical services. In a predominantly paediatric mass casualty event, young people and adolescents aged 12 years and over are often considered for care in adult centres. Where this is the case, an appropriate link with paediatric services should be available.

Standards

No.	Standards	Indicators	Evidence
62	CYP must be specifically included in the strategic and operational planning in preparation for, and response to, major incidents and business continuity arrangements. This should be in line with relevant national/ regional structures and include adaptations for triage, clinical capacity and mental health support	• Evidence that CYP are specifically considered in both strategic and operational planning for major incidents	NHS England NHS Emergency Preparedness Resilience and Response Framework NHS Scotland. Preparing for Emergencies Guidance. NHS Wales Emergency Planning Core Guidance, Northern Ireland Emergency plans and response - information and guidance
63	All health care workers with a role in a major incident response must be involved in appropriate training and incident exercises	• Evidence of site wide, multi-disciplinary team training for major incident response	N/A
64	EDs should have representation on pandemic planning groups	• Evidence of an ED representative on the group	N/A

Practice example

Practice example 1: Royal Hospital for Children Glasgow: Major incident simulation programme in a paediatric major trauma centre

A six-monthly major incident simulation multidisciplinary training programme has been established at the Royal Hospital for Children in Glasgow.

For each simulation the aims include:

- Identifying strengths and challenges in the major incident plan and developing changes to further strengthen it.
- Building staff confidence in their role.
- Utilising the simulation exercises as a form of staff training for both technical and non-technical skills.

An experienced faculty was identified to plan, write and facilitate the simulation exercises. They have now facilitated six-monthly major incident translational/transformative in-situ simulation events for over three years with over 50 participants taking part in a single simulation. Different areas within the major incident plan have been tested, or identified as an area for repeat testing, following system and plan changes. After each simulation, both a hot and an organisational debrief have taken place to build staff confidence and ensure psychological safety, whilst identifying any organisational changes required and areas of the plan that need to be altered or strengthened.

The simulations have resulted in some significant changes to the major incident plan, for example additions to the major haemorrhage response and new action cards after additional roles were identified. Feedback has consistently demonstrated an increase in staff confidence in their roles.

Overall, translational/transformative major incident in-situ simulation has strengthened the organisation's major incident response and has been an excellent addition to staff training for major incident management.

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Chapter 10: Safe transfers

Safe patient transfers require forethought, preparation, practice and training. Children and young people (CYP) requiring inter-hospital transfers are often critically ill, and some will have complex conditions needing tertiary input. Within some areas, paediatric medical and surgical specialities can be fragmented, posing additional challenges in the safe transfer of a CYP to a specialist unit.

Intra-hospital transfers, e.g. moving patients from the Emergency Department (ED) to medical imaging or a high dependency area, present similar logistical problems and also require careful planning to ensure that the right staff are present, with the right kit, at the right time. These overarching principles are common to all safe and successful transfers.

Pre-hospital (primary) transfers

Paramedics and other pre-hospital medicine specialists must be equipped and trained to safely transfer CYP to the nearest appropriate medical facility, with the additional option of calling for further advice and assistance through a critical care referral phone line, when needed.

The receiving hospital should be pre-alerted to the arrival of any seriously ill or injured CYP as soon as is practical, using the pre-hospital ATMIST communication tool to summarise the CYP's clinical condition[261].

Major trauma[262]

Since the development of regional Major Trauma Networks, pre-hospital trauma bypass tools have provided protocols for transferring seriously injured CYP directly to designated Major Trauma Centres (MTCs) which, in many cases, will result in ambulances bypassing the nearest ED.

Paediatric inpatient reconfiguration

Similarly, where centralisation of services has resulted in local facilities losing on-site paediatric, surgical or other specialist expertise, local paediatric ambulance protocols should ensure that seriously ill CYP are transferred directly to the nearest appropriate paediatric care provider, that is unless either i) resuscitation is ongoing, or ii) life or limb is compromised. In such time-critical situations, these CYP must be transferred to the nearest ED, where the receiving hospital should initiate lifesaving interventions, including advanced paediatric airway, respiratory and circulatory life support measures at the earliest opportunity.

Local hospitals must ensure that skilled personnel, trained in advanced paediatric life support (APLS), are always available to safely resuscitate and stabilise a critically ill CYP, whilst arrangements for retrieval and definitive treatments are put in place[263]. See Chapter 3: Workforce and training: Standards 10 and 11 for more information. Regional Paediatric Critical Care Transport Services (PCCTS) can be called upon by local hospital teams for immediate clinical advice and the mobilisation of their critical care retrieval teams if required.

Intra-hospital transfers

As with any other type of patient transfer, good planning and preparation are essential prior to an *intra*-hospital transfer if patient safety is to be maintained. EDs should have standardised arrangements for managing patient transfers within their own hospitals, ensuring that the same principles of tasking the right staff, with the right kit, at the right time are always employed. Transfer bags containing appropriate equipment and drugs should always be readily available and these should be checked regularly according to locally determined policies, as per Resuscitation Council guidance[264].

When planning for the transfer of critically ill or injured CYP *within* hospital areas, the following factors should be considered[vii]:

- The type of patient being transferred and whether the transfer is essential - assess the benefit and timing of the transfer relative to the risk of deterioration
- The composition and competencies of the medical transfer team
- The drugs (including gases) and equipment required
- Monitoring requirements
- Appropriate safe restraint for patients and equipment throughout the transfer

Checklists and simulation training exercises can assist clinical teams to prepare for intra-hospital transfers, enabling the identification of potential problems, and prompting departmental conversations and multidisciplinary governance discussions to overcome any identified issues.

Timeliness

When a decision has been made to admit a CYP from the ED to an inpatient paediatric bed and they are clinically ready to proceed, the individual should be transferred from ED within one hour[52] to maintain ED patient flow. If the CYP remains clinically unstable, they should not be transferred to an inpatient ward, irrespective of ED activity or time pressures[265].

However, some critically unwell or injured CYP will need to be transferred to other areas of the hospital for ongoing treatment whilst clinically unstable, as the destination (for example Paediatric Intensive Care Units (PICU) or theatres) is deemed a safer place. Decision making around the transfer of clinically unstable CYP should entail a multidisciplinary discussion and agreement between consultants from ED, paediatrics, anaesthetics, surgery and PICU as appropriate.

Inter-hospital (secondary) transfers

In many instances, following initial resuscitation and stabilisation in an ED, a critically ill or injured CYP will require transfer to a regional PICU to receive ongoing critical care.

Regional PCCTS provide clinical advice and guidance on managing critically ill and injured CYP via 24-hour telephone lines. They can elicit input from other specialities as needed and provide logistical guidance and clinical support when patient transfer is required.

PCCTS should be approached when clinical advice is required regarding the resuscitation or ongoing care of a CYP, or the CYP needs escalation of care beyond what can be provided locally. Calling with details of all relevant patient information, observations and investigations ensures that the PCCTS team can provide appropriate advice in a timely fashion and help with decisions regarding ongoing care.

[vii] These headings reflect the principles of safe transfer outlined in PCCS Specialist Paediatric Critical Care[263], which can be used to inform in-hospital practice when planning and preparing for transfers within hospitals.

“Time-critical” transfers

Whilst most inter-hospital transfers of a critically ill or injured CYP are undertaken by PCCTS, for certain “time-critical” conditions (e.g. severe head injury[266], intracranial bleeds, spinal injuries, thoracic vascular trauma), it may be necessary for staff from the local receiving hospital to transfer the CYP to avoid delay and potential clinical deterioration. The benefits of rapid transfer by a local team must outweigh the risks of waiting for a specialist retrieval team to arrive to transfer the patient and should not compromise patient safety. Such decisions require consultant to consultant discussion between the referring hospital and the PCCTS, who can facilitate further discussion with relevant tertiary centre specialists and receiving units.

Teams performing time-critical transfers must comprise at least two experienced members of staff, trained to manage any potential deterioration encountered during paediatric transfers. Given the potential need for airway intervention, time-critical transfers are commonly performed by experienced anaesthetists with relevant skills and training. The referring consultant and senior nurse on duty are responsible for establishing the suitability of the transfer team members.

Healthcare organisations must ensure that protocols for facilitating time-critical transfers are in place, detailing that suitably skilled personnel are readily available and appropriately indemnified, that necessary drugs and equipment are immediately to hand and have been checked in accordance with local policy, and that the patient, equipment and staff are appropriately restrained during the transfer. The local ambulance control centre should be informed that a ‘Time-Critical Emergency Patient Transfer’ is required, and these conversations should be suitably documented.

The parents and carers of CYP requiring inter-hospital transfer should be given relevant and helpful information regarding the transfer, including the receiving hospital’s location, the specific location of the unit to which their child is being transferred, contact telephone numbers (for both the local and the receiving hospitals), and practical information such as car parking arrangements[263].

Training and resources

Regional and national training programmes employing simulated clinical scenarios can help prepare local teams to safely transfer patients. Advanced Life Support Group (ALSG) offers a transfer specific course - the Neonatal, Adult and Paediatric Safe Transfer and Retrieval (NAPSTaR) course[267]. PCCTS also offer support for the care of critically ill CYP through the provision of outreach education and training programmes at a regional level, including time-critical transfer checklists[268]. Local hospitals should invest in attending this training.

Readily available transfer checklists can also help avoid common pitfalls. For further information, see the Practice Examples below.

Standards

No.	Standards	Indicators	Evidence
65	Each region has a Paediatric Critical Care Transport Service (PCCTS)	• Evidence of a regional PCCTS. • Evidence detailing regionally agreed transfer arrangements for critically ill or injured CYP within the UEC network (to also include agreed processes and arrangements for time-critical transfers by local teams)	Specialist Paediatric Critical Care Transport Services Standards, from Quality Standards for the Care of Critically Ill Children Guidelines for the Provision of Paediatric Anesthesia Services 2025

66	The regional PCCTS has a dedicated 24-hour critical care referral phone line providing clinical support and advice, and coordinating retrievals and transfers for critically ill or injured CYP	- Evidence of a 24-hour critical care referral phone line	Specialist Paediatric Critical Care Transport Services Standards, from Quality Standards for the Care of Critically Ill Children
67	Local hospital facilities have appropriate staff and equipment readily available for time-critical inter-hospital transfers	- Evidence of safe transfer and escalation policies[269] - Evidence of local protocols for "time-critical transfers" in place and agreed with EM, paediatric and anaesthetic teams - Audit of local/regional time-critical transfers - Appropriate transfer drugs and equipment (as outlined in PCCS Quality Standards for the care of Critically ill Children[263] & Resuscitation Council (UK) guidance) are always readily available and checked regularly as determined by local policies, with documented evidence of these checks	Resuscitation Council UK. Quality standards: Acute care equipment and drugs list Specialist Paediatric Critical Care Transport Services Standards, from Quality Standards for the Care of Critically Ill Children
68	Any staff involved in the stabilisation and transfer of CYP should be appropriately trained in this area, as per local agreements	- Evidence that staff involved in the stabilisation and transfer of critically ill or injured CYP have had sufficient training in this area, with a focus on local and regional guidance. This should incorporate training for a broad multidisciplinary group including ED, anaesthetic, intensive care, paediatric and pre-hospital emergency care staff and other team members as locally appropriate - Evidence of regular simulated paediatric critical care scenarios, where transfer considerations are included	Handover; skills to enhancing the PHEM – EM interface
69	Parents and families of children transferred between hospitals are given practical help and information detailing their child's transfer destination	- Evidence that parents receive transfer destination details. Since most transfers typically follow an established pathway (e.g. to a regional PICU, MTC, Burns Unit, Neurosurgical Unit) pre-prepared parental information leaflets should be made available	N/A

70	All EDs should have appropriate guidelines and checklists in place to safely manage intra-hospital patient transfers	• Evidence of safe ED intra-hospital transfer policies. • Use of a standardised paediatric transfer tool e.g. STOPP.	See links to latest STOPP tools listed under Practice Examples
71	All EDs should test their transfer systems annually, using simulated patient transfer exercises involving all appropriate members of the multidisciplinary team, with regional PCCTS support	• Evidence of regular MDT simulated patient transfer exercises.	N/A

Practice examples

Practice example 1: North West London's critical care network - Transfer training

North West London's Critical Care Network *Transfer Course Aide Memoire* (a 2017 Patient Safety Award winner) is a comprehensive guide designed to support healthcare professionals in the safe and effective transfer of critically ill patients. It is crucial for minimising risks and ensuring that critically ill patients receive continuous and appropriate care during transfers. Updated in 2023, this concise and helpful pre-transfer check list remains freely available online. London's Critical Care Network also offers additional online transport-related training videos and a transport-specific training course.

More details:

https://londonccn.nhs.uk/wp-content/uploads/aide-memoire-13.pdf
https://londonccn.nhs.uk/professionals/trainingandresearch/transfers/

Practice example 2: Safe transfer of the paediatric patient tool (STOPP)

The STOPP Tool is used to standardise and streamline the transfer process, ensuring that all necessary information and precautions are taken to safely move a paediatric patient from one hospital to another. It is a widely used checklist when transferring CYP between hospitals that includes risk assessment, transfer category, staff and equipment requirements, and patient-specific instructions. This ensures that all relevant medical information is communicated clearly and accurately. The tool emphasises the importance of clear communication between the referring and receiving hospitals, including confirmation of bed availability and transfer acceptance. Although originally designed for inter-hospital transfers, the STOPP tool is now also being locally applied to intra-hospital transfers, as its principles are similarly applicable.

More details:
These forms can be accessed from various sources depending on the region, including:

https://cats.nhs.uk/wp-content/uploads/STOPP-Tool-V16-Oct-2024-eversion.pdf
www.sort.nhs.uk/Media/Guidelines/Referral-forms/STOPP-safe-transfer-of-paediatric-patients-tool-interhospital-transfer-tool.pdf

Chapter 11: Death of a child or young person

The sudden and unexpected death of a child or young person (CYP) is devastating for the family and is challenging for all involved. Parents react individually and many feel overwhelmed. A range of different feelings are experienced in an emergency situation and subsequent death of a child; anger, outrage, utter disbelief, guilt, blame and complete sadness. At such a difficult time families need guidance, support, information and honest communication. Recognising the impact the death of a child can have on the healthcare staff involved is also essential. Good communication and coordination between all professionals and with parents, carers and relatives is vital so that families know what is happening, are involved as far as they are able and encouraged to make informed decisions.

Depending on the nature of the CYP's condition and death, whether resulting from accident or illness, there are several legal requirements that need to be met. Each nation has guidance [270,271,272,273,274,275,276,277] outlining a joint agency response when there is a death that may be due to external causes, is sudden with no clear cause, occurs in custody or under the Mental Health Act, or suggests unnatural circumstances. Stillbirths without a healthcare professional present also fall under this category.

"When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learnt" Working Together to Safeguard Children, 2023[270]

Procedures in the case of unexpected deaths

There are guidelines for sudden and unexplained deaths in infancy and childhood (SUDIC) [278]. In the case of the unexpected death of a CYP, local agreed guidelines should, as a minimum, include the following:

- How and when to stop resuscitation
- Supporting the parent or carer and family/siblings
- How and when to involve the police
- Pathology sampling
- Post-mortem examinations
- Consent
- Cultural/religious beliefs

In the case of the unexpected death of a CYP, there are procedures that must be followed including reporting to the coroner (or equivalent), involvement of the designated paediatrician for unexpected deaths and, when applicable, initiation of the child death review process[271]. Specific legal requirements include verification of the fact of death, certification and notification of death and there must be an agreed process with the coroner, or equivalent, for taking pathology samples immediately after death. There should be policies and guidelines in place to support Emergency Department (ED) staff in understanding their role in these procedures, including a clear understanding of local processes on organ donation in CYP. It is good practice for EDs to have a checklist to cover all of these important tasks.

If a CYP has died unexpectedly at home, the ambulance and police provide an immediate response where either resuscitation will be initiated/continued, or death is confirmed. If there is active resuscitation, the CYP and their parents or carer should be transferred to a hospital with paediatric facilities, where resuscitation is continued or a decision to stop is made and death is confirmed. If a CYP is being resuscitated, parents should be allowed to stay with them, if that is what they wish, and kept informed of all that is happening. If the family would prefer for their child to remain at home, the attending ambulance and police team should liaise with the paediatric team at the hospital to plan an appropriate response under the circumstances. In cases of unexplained deaths, it is preferred that all CYP should be taken to the hospital in order to begin investigative procedures. In many areas, a CYP whose death has been confirmed out of hospital will be taken to the ED, rather than directly to the mortuary. There should be clear local guidance on the pathway and processes to follow. It is important to recognise parents or carers have a choice on whether to remain in the ED after the death of their child, and not to assume that all parents would want this.

Across the nations, there is a designated Joint Agency Review in place for SUDIC. In such cases, there are SUDIC or designated doctors who are notified before review processes in England, Scotland and Wales[270, 279, 280].

In the unexpected death of a CYP up to the age of 18 involving, for example, a cause such as suspected deliberately inflicted injury, neglect, suicide, interpersonal violence or a road traffic accident, the child death review process will run in parallel with police investigations[270].

Supporting families

Whether the CYP has died at home, in the community, or within the ED, talking to parents or carers and informing them of the death should be managed sensitively, honestly and clearly. An experienced member of staff must be identified to support parents, carers and families under these difficult circumstances to help ascertain their wishes. There are many resources available that offer guidance and support, outlining key steps and principles in communicating with parents, carers and families after the death of a child [281].

Breaking bad news guidance[281] and training should be available to all staff. The way in which bad news is communicated is an important factor in how the information is received, understood and processed. Health professionals should receive education and training to develop the necessary skills to break bad news sensitively, but effectively. There should be a designated appropriately decorated and furnished private space within the ED for staff to discuss upsetting information with families. Recognising the importance of parents' and carers' spiritual, cultural and family beliefs and values should be considered in all communications. It is always best to ask families how we should look after them under these most difficult of circumstances. Families should be offered keepsakes, such as memory boxes, where possible, and signposted to bereavement and faith support and counselling services if they wish.

Supporting families to care for their child after death and encouraging them to be involved is essential. Depending on the circumstances of the death, parents may wish to take their child home or to a hospice, if available, where facilities are available to support the family. This should be discussed with a bereavement support professional or the hospice family/bereavement support team and with the coroner (or equivalent) if applicable. EDs may have a bereavement room which allows parents, carers and families to spend time with their child after death, with support from trained healthcare and other staff.

Before leaving the ED, parents should be provided with sufficient information on the legal requirement for registering the death, on the involvement of the designated paediatrician, the police or coroner (or equivalent) when required and the child death review process. The effects of the death of a child can be far-reaching and will impact on wider family and friends. It is important to identify early support for all those affected and guide the family to appropriate resources and bereavement support that may be required to help in the days, weeks and often years to come. An appointment with the hospital bereavement support service, or other bereavement services offered locally, should be made for the next 24-48 hours. Such professionals are trained and skilled in supporting families and identifying complications experienced as a result of grief and loss.

The parents or carers should also be offered an appointment to see a consultant paediatrician to explain the cause of the unexpected death and offer support at an appropriate time interval (often between one to three months) after the death[282]. The meeting is usually informed by the results of the post-mortem examination, if held and available. This can also provide valuable feedback to the ED team on their handling of the death in the department and support for the family.

Further support for families can be found thorough Child Bereavement[283] UK, Winston's Wish[284], Together for Short Lives [285] and The Lullaby Trust[286].

Supporting staff

Supporting healthcare staff in managing the death of a CYP is essential, and training and education is important in preparing staff for caring for bereaved parents. Staff can be profoundly affected by the death of a CYP and opportunities for debrief, personal reflection and supervision should be available. This can help with learning, and support changes to practice that will benefit the department and care of families. Staff involved should also be signposted to counselling services where locally available[287, 288].

Child death review process

Child death review systems inform national multi-agency learning, aid the development of national policy and help identify factors which can reduce preventable deaths. Learning from each review is shared to improve policies and practice. Legislation around child death is different in each of the four nations, and providers of emergency care who manage child death need to be familiar with and comply with local policies and processes, both statutory and non-statutory. Current legislative policies in each of the four nations are:

- In England, the current arrangements for reviewing child deaths are described within Working Together to Safeguard Children. Further operational guidance[271], co-owned by the Department for Health and Social Care and the Department for Education, provides information about the different roles within the Child Death Review Panel. Local Safeguarding Children Boards are responsible for ensuring that a review of each death of a CYP is undertaken by a Child Death Overview Panel (CDOP).
- In Wales, a Single Unified Safeguarding Review will occur following a Child Practice Review[274]. Additionally, Public Health Wales have published Procedural Response to Unexpected Death in Childhood (PRUDiC), which provides more detailed guidance on the process to be followed[289].
- In Scotland, the Child Death Review process should be followed as outlined by Scottish Government in the National Guidance for when a CYP dies[290]. The Child Death Review Panel has also published further guidance which outlines Child Death Review processes[291].
- In Northern Ireland, a Case Management Review (CMR) occurs when an incident meets certain criteria. The Safeguarding Board for Northern Ireland (SBNI) informs the CMR Panel. The National Child Death Review Panel and SBNI advise on necessary policies and procedures (pending Northern Ireland legislation).

All of the UK nations have databases that collate information on CYP deaths. They aim to record and monitor the patterns and causes of death in CYP to provide evidence and recommendations to reduce any risk factors contributing to unexpected child deaths.

- In England, child death review partners[270] via a CDOP conduct reviews and report to the National Child Mortality Database[292] that receives data on all CYP deaths in England up to their 18th birthday.
- Wales has an established Child Death Review programme[293] that ascertains and reviews the deaths of CYP born or normally resident in Wales until their 18th birthday.
- Scotland conducts reviews of all CYP deaths up to the age of 18 and extends this to care leavers up to the age of 26. Deaths are reported to the National Hub.
- In Northern Ireland, a database is currently being formed.

Adolescents / 16 to 17-year-olds

When dealing with the death of a 16- or 17-year-old, it is important to remember the individual is still legally a child, regardless of whether they are seen in an adult or paediatric ED, and all statutory and non-statutory processes regarding child death will still apply.

If the responsible clinical team has limited experience and expertise in managing child death processes, it would be appropriate for support and advice to be available from a paediatrician.

The processes and standards described in this chapter apply to all CYP up to their 18th birthday.

Standards

No.	Standards	Indicators	Evidence
72	All EDs caring for CYP up to the age of 18 have an agreed policy in place for responding to the unexpected death of a CYP as per their national guidelines	• Evidence that policies include the minimum requirements outlined in this chapter • Evidence that the designated paediatrician is advised as soon as possible about the unexpected death of a CYP	England: Working Together to Safeguard Children Northern Ireland: Co-operating to Safeguard Children and Young People in Northern Ireland Scotland: NHS Scotland Death of a Child Wales: Protecting Children in Wales
73	CYP who have died outside of the hospital setting are transported to a hospital with paediatric facilities*	• Evidence of joint pathways with pre-hospital services	See evidence in standard 72
74	All EDs caring for CYP provide training for staff on how to support parents/carers in response to the unexpected death of a CYP and have processes in place to support the staff involved	• Evidence of training • Evidence of trauma-informed service delivery • Evidence of early team debrief • Evidence that staff are offered support	See evidence in standard 72

75	Before leaving the ED, bereaved parents/carers should be provided with an information pack including: • The legal requirement for registering the death. • Any involvement of the designated paediatrician, the coroner or the police and the child death review process. • Details of the hospital bereavement support service with arrangements for an appointment within the next 24-48 hours.	• Evidence of an information pack with appropriate contents, including relevant information on local processes and policing arrangements. • Evidence of training on the information provided for parents and how to issue the pack.	See evidence in standard 72
76	All EDs should cooperate with the designated paediatrician and the child death review process to ensure any learning is shared between agencies for all CYP up to the age of 18.	• Evidence of appropriate engagement with the review team and process. • Evidence of a process in place to identify and action any learnings specific to the ED emerging from child death reviews.	See evidence in standard 72

* *If a family would prefer their infant to remain at home, the attending ambulance and police team should liaise with the paediatric team at the hospital and with the police investigating officer to plan an appropriate response. In such circumstances, a GP, certified member of ambulance staff or forensic medical examiner may confirm that the infant has died* [278].

Practice example

Practice example: The Royal Cornwall Hospitals NHS Trust

The Royal Cornwall Hospitals NHS Trust has implemented a comprehensive policy for managing the death of CYP up to the age of 18 in the ED, ensuring a coordinated, compassionate and professional approach. This policy includes immediate resuscitation efforts unless clearly inappropriate and the notification of relevant agencies as part of a Joint Agency Review. It clearly delineates roles for various staff members, such as the Named Doctor for Child Death Review, Consultant Paediatrician, Senior ED Doctor, Family Support Nurse, and Lead Nurse. The hospital provides emotional and practical support to bereaved families, offering memory boxes and mementoes. Multi-agency collaboration is emphasised, with regular discussions involving police, paediatricians, social care, and other relevant parties. Thorough documentation and investigation of the circumstances surrounding the CYP's death are conducted, with preliminary post-mortem discussions informing the review process. Staff receive regular training on managing CYP deaths and supporting families, and the policy is continuously reviewed and updated to incorporate best practices and lessons learned. This approach ensures that the death of a CYP is managed with the utmost care, compassion and professionalism, providing essential support to families and contributing to continuous improvement in care practices.

More details:
https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Paediatrics/PalliativeCareAndChildDeath/DeathInChildrenUpTo18YearsOfAgeEmergencyDepartmentPolicy.pdf

Chapter 12: Information system and quality care indicators

Children and young people (CYP) should receive coordinated, competent and family-centred care, as outlined in Chapter 1: An integrated urgent and emergency care system. Urgent and emergency care (UEC) settings should implement safe information systems and quality care indicators to facilitate the best quality of care.

Information systems

The development of integrated shared health records, through a consistent/ single unique identifier[26,294] is a national priority. It is recognised that local issues around information governance often have different risk management practices than agreed standards, and therefore these differences need to be addressed and managed. Networks of healthcare and social care providers (e.g. Emergency Departments (EDs), general practices, schools and social service departments) need intuitive information systems that communicate with each other. An example of this in practice, Lambeth and Southwark local healthcare record[295], has been showcased.

Emergency care information systems should provide basic demographic and episode-related information, facilitate good practice, and minimise the administrative burden on clinical staff. They should meet the needs of patients, clinicians, managers, commissioners and regulators and, increasingly, ensure good quality care indicators.

The information system should encompass, or at least be able to link with, all sites in the local network which provide UEC to CYP; see Chapter 1: An integrated urgent and emergency care system, Sections Service planners and providers and Alternatives to ED for further information. All current health care episodes for CYP should be available on the system to facilitate appropriate communication and follow-up. All previous episodes of health care for CYP should also be available including clinics in the community, maternity, hospital-based specialty clinics, visits to other health professionals and all UEC, mental health and ambulance episodes.

Representatives from UEC services across the UK nations should engage with national information technology policy and programmes to influence the national agenda, and with local service providers to influence the design of local systems. This includes using electronic patient records, where possible. See Chapter 1: An integrated urgent and emergency care system Section 'The whole pathway approach to urgent care' for further information.

An ideal information system should include the following information:

- Demographic data (name, address, date of birth)
- Name of person with parental responsibility
- Contact telephone number(s) for parent(s)/carer(s) (including mobile)
- Name of persons accompanying CYP and relationship to the CYP
- Mode of transport to hospital
- Name of nursery/school/college, if applicable
- Name of GP/midwife/health visitor/school nurse, as applicable
- Presenting complaint
- The incident location, if the presentation is for an injury, for injury prevention surveillance

- Previous attendances to the same ED/other local EDs
- An Emergency Care Plan (ECP) when treating a CYP with complex needs, which should be held electronically wherever possible (See Chapter 7: Children and young people with complex needs, Standard 48 for more information)
- Current and previous safeguarding episodes/concerns, including details of a Child Protection Plan if in place, and contact details for any social worker(s) involved with the CYP/family

And should perform the following functions:

- A communication system, including linkages to the hospital's systems for recording hospital episodes, and regional/national data, as well as an automated process for informing the child's primary care team of the attendance
- Real-time service delivery function, such as patient tracking within the UEC setting, the electronic ordering of tests, electronic prescribing, etc.
- Real-time clinical support, including alert categories, linkages to individual care plans, and a method of identifying previous attendances and frequent attenders
- A reporting system with good clinical coding

Other sources of information should be readily available to support UEC healthcare staff including the TOXBASE[296] website, standards for emergency care discharge summaries[297], local clinical or operational guidelines, clinical decision support software, online medical information services, and search engines.

> ***"The technology we use needs to be faster and more responsive. The notes systems need to link up within a single NHS trust and be accessible to view from external trusts. This makes MDT working harder and means the patient and families must repeat the same information several times!"*** Clinician, RCPCH& Us 2025

Clinical coding and emergency care data sets

In England, it is a requirement for all EDs to provide reports in keeping with the Emergency Care Data Set (ECDS)[298]. This contains an agreed set of data which is SNOMED Clinical Teams compliant. SNOMED-CT is an internationally agreed system of clinical coding which has been adopted by NHSE. All Northern Ireland EDs will also use the ECDS, and a mandate has been issued by the Welsh Government for national implementation of a Welsh ECDS (WECDS) by 2026. In Scotland, use of the A&E Datamart[299] supports ECDS data capture.

The ECDS system is a minimum standard, and EDs can choose to collect further information relevant to understanding performance, e.g. presenting complaints, investigations, treatments and discharge diagnosis. The system also includes information to facilitate audit and clinical governance within the UEC setting (e.g. national recommendations, and injury surveillance) and information about service provision (e.g. timings of the patient journey and staff performance statistics). As development progresses, both nationally and locally defined quality outcome measures should be incorporated. These should be monitored and enhanced by the Professional Record Standards Body (PRSB) to ensure that discharge information is promptly shared with the CYP's GP to facilitate any ongoing care and treatment[297].

It is essential that mixed EDs ensure systems possess the functionality for the disaggregation of paediatric data from adult data. Special consideration should be given to ensuring this is achievable for the adolescent patient cohort.

Injury surveillance

Injuries are the most common cause of death and preventable morbidity in CYP aged one year and over. Primary injury prevention is one of the least well researched and underdeveloped elements of CYP services. Knowledge of the epidemiology of injury is critical to prevention. Information about accidents in the local area should be available from the ED database, and can be used to inform local government policy, the media, and the police, within the limits of patient confidentiality[300].

The National Major Trauma Registry (NMTR)[301] is the recommended method of assessing the quality of trauma care and outcomes following severe injury. In Scotland, the Scottish Trauma Audit Group (STAG)[302] audits the management of trauma patients. The RCEM Pain in Children clinical audit[303] on use and timeliness of analgesia in CYP with injuries is another important quality audit measure.

Emergency and urgent care quality indicators

Sharing performance data across the network will facilitate improving quality in a collaborative way that is best for patients and families.

The Department of Health clinical quality indicators for EDs in England were introduced in April 2011[304] stating that 'good' care will invariably satisfy six criteria[305].

1. Safe
2. Effective
3. Efficient
4. Patient-centred
5. Timely
6. Equitable

In 2025, NHSE published their UEC plan, committing to further improvements on meeting the four hour standard[306].

RCEM's position statement[307] outlines recommendations for Site Specific Reporting against Emergency Access Standards and the Reporting of Disaggregated Data.

The NHS Wales Performance Framework[308] describes performance measures for UEC, with a focus on delivery of the six goals programme.

Goal 1: Coordination, planning and support for populations at greater risk of needing UEC.
Goal 2: Signposting people with urgent care needs to the right place, first time.
Goal 3: Clinically safe alternatives to admission to hospital.
Goal 4: Rapid response in a physical or mental health crisis.
Goal 5: Optimal hospital care and discharge practice from the point of admission.
Goal 6: Home-first approach and reduce risk of readmission.

It is likely that unplanned reattendance rates for CYP, especially for children less than five years, will be appropriately higher than adults due to the evolving nature of childhood illness. Adult and paediatric rates can be usefully monitored separately, and ideally the reattendance rates for children under five should be monitored as a subgroup of 0-16 years. An audit of these standards will provide vital evidence for units to monitor and assess the quality of care that is being provided.

Patient reported experience and outcome measures

Patient reported experience measures (PREMs), and patient reported outcome measures (PROMs) provide a method to measure patient and caregiver satisfaction. This is a fundamental aspect of value-based healthcare that provides CYP and their families with a mechanism to provide feedback about their care that can ultimately be used to deliver service improvements. The evidence base for PROMs/PREMs in paediatric EDs is developing rapidly. The RCPCH has developed a PREM tool for use in UEC settings[309].

Standards

No.	Standards	Indicators	Evidence
77	All health care practitioners treating CYP in the UEC network have access to information systems that provide the required demographic episode-related information and functionality	• Evidence of access to CYP demographic and episode related information • Evidence of integrated health information systems, so that data on all local health service contacts are available within the UEC setting	N/A
78	All EDs treating CYP collect the necessary ECDS and performance data that can be used to improve services locally and to benchmark performance nationally	• Evidence that injury surveillance data is collected and accessible. • Participation in the quality improvement system for major trauma through the appropriate national trauma registry. • Evidence of using ECDS and quality care indicators to enable service planning and improvement. • Evidence that PREM/PROM data is collected	N/A
79	All EDs treating CYP should adhere to the Emergency Care Discharge Standard	• Evidence that discharge summaries are compliant with PRSB standards	Emergency Care Discharge Standard - PRSB
80	All health organisations providing UEC to CYP must collaborate with national or regional information programmes to disaggregate data for CYP to involve and inform of the needs of patients, clinicians, managers and service planners/ commissioners in developing emergency care information systems	• Evidence of collaborative working with national or regional information data sets to inform the development of emergency care information systems	N/A

Practice example

Practice example: Southwark and Lambeth: The local care record initiative

The Local Care Record initiative in Southwark and Lambeth is an example of good information integration, securely connecting local hospitals and GPs to share electronic patient records. This system ensures that patient information remains in its original location and is only accessed by authorised healthcare professionals directly involved in patient care. By facilitating faster and more reliable information sharing through a secure online portal, the Local Care Record enhances the quality, safety, and efficiency of patient care, while maintaining strict privacy standards and giving patients control over their data.

Additionally, the Local Care Record improves the overall patient experience by reducing delays and potential errors associated with traditional methods of information sharing, such as secure post or email. Patients benefit from more coordinated and informed care, as healthcare professionals have access to the most up-to-date information, including test results and medication records. This initiative not only supports better clinical decision-making, but also reassures patients that their personal information is protected and used solely for their direct care.

Chapter 13: Research for paediatric emergency care

Research in paediatric emergency medicine (PEM)

The National Institute for Health Research (NIHR) has highlighted Emergency Medicine[310] and Paediatrics[311] as key development areas. This focus should enhance resources for PEM research. Engaging with existing infrastructures will enable broader participation in research, regardless of prior academic experience. This is important, as limited evidence and delays in applying research cause significant variation in care. Research is important for health outcomes, as research-active hospitals have been found to have lower mortality rates, beyond the research participants[312]. Emphasis should be on both primary and secondary research to understand the lived experience of children and young people (CYP) in Emergency Departments (EDs), to generate new information and evidence and synthesise existing evidence, ultimately translating knowledge into tangible clinical improvements in the emergency care of CYP.

Paediatric Emergency Research in the UK and Ireland (PERUKI), established in 2012, is a PEM research network which brings together clinicians and academics to collaboratively develop and deliver high quality multicentre research. This network has demonstrated that the ED is an invaluable environment for research, with patients presenting with a wide range of childhood illness and injury. Conducting research directly within the ED is also beneficial as it can significantly reduce the time for research findings to be put into clinical practice. However, research in an ED setting poses several challenges including funding limitations, data quality and consent issues, in addition to the significant clinical service and performance pressures[313].

PERUKI's aim is to improve emergency care for CYP by:

- Facilitating collaboration and coordinating research activities with participating institutions
- Developing a research agenda to produce high-quality studies in the short, medium and long term
- Creating an environment for communication between academics and clinicians, with the efficient translation of research findings into clinical practice
- Promoting sharing of expertise within the UK and Ireland, and with the rest of the world
- Mentoring junior PEM researchers to foster a sustainable research network

PERUKI initially established the research priorities for PEM clinicians in the UK and Ireland in 2015[314] and has delivered high-quality multicentre studies addressing many of these initial research questions. For example, the Petechiae in Children (PIC) study provided robust evidence regarding the assessment and management of febrile children with non-blanching rashes and has been utilised in national guidance from the British Society of Antimicrobial Chemotherapy[315]. The Emergency Treatment with Levetiracetam or Phenytoin in Status Epilepticus in Children (EcLiPSE) study led to a change to the Advanced Paediatric Life Support (APLS) guideline for management of convulsing children[316]. PERUKI has been involved in attracting an estimated £15 million in successful grant applications for PEM research and recently updated the organisation's research priorities, working collaboratively with the James Lind Alliance in a Priority Setting Partnership with clinicians, CYP and caregivers[317]. The next top 10 research priorities identified include: Sepsis; Mental health; Overcrowding; Trauma; Wheeze; Monitoring within ED; Improving communication with patients and families; Care for children with special educational needs and disabilities; Triage methods; and working with other services to reduce unnecessary ED attendances.

These successes have been driven by the grassroots involvement of PEM clinicians who, despite often limited resources and prior research experience, have been key contributors in the design and delivery of this work. PERUKI provides a supportive and safe environment in which novice researchers can develop the necessary key skills to further develop this vision.

PERUKI has also facilitated involvement with research on a global scale through joining the Paediatric Emergency Research Networks (PERN) group and working with its member organisations. However, close relationships with existing networks and organisations closer to home are also key to PEM research. PEM research frequently overlaps with other specialties, as successful delivery requires multiprofessional collaboration and team working. Working with the NIHR Children Specialty's Clinical Studies Groups, and other research networks such as General and Adolescent Paediatric Research in the United Kingdom and Ireland (GAPRUKI) will enable common goals to be achieved. Engagement with regional Clinical Research Networks and local Research & Innovation departments is essential, as their expertise and support structures may help unlock the full potential of PEM teams where there is enthusiasm to be involved. All EDs that are Paediatric Major Trauma Centres (MTCs), affiliated to a university or have at least one dedicated PEM consultant, should aim to have a nominated lead for paediatric emergency research and PERUKI membership[318].

RCPCH provides guidance on several aspects relevant to PEM research. In 2016, the RCPCH produced the Infants', Children's and Young People's Child Health Research Charter[319]. This Charter supports CYP, families and health professionals in talking about child health research, guiding discussions to ensure everyone is clear on what is happening and when, and why child health research is important. The RCPCH has also compiled a list of relevant guidance, tools, resources, and e-learning to support research[319].

Standards

No.	Standards	Indicators	Evidence
81	All EDs that are Paediatric Major Trauma Centres, affiliated to a university or have at least one dedicated PEM consultant should be in good standing with PERUKI	• Site representation at a PERUKI update within the past two years (e.g. PERUKI, RCPCH, RCEM conferences) AND one of the following; • Completion of at least one study review per year. • Submission of at least one *Expression of Interest* to participate in a study within the past two years	NIHR: Participation in health research may be linked to better care and performance
82	All ED's treating CYP should review published research and consider how it can inform quality improvement or be implemented in practice	• Evidence of a departmental Clinical Governance programme addressing improvements in clinical practice, updating clinical guidelines according to latest evidence	N/A

Practice Example

Practice example: The CURLY study[320]

The CURLY study is an NIHR-funded study evaluating the impact of different antibiotic durations on the successful treatment of urinary tract infections. Like many PERUKI research studies, a community of practice is developed involving research nurses, principal investigators (PIs) and associate PIs. For CURLY, WhatsApp has proved a successful method of allowing research teams real-time access to the PI to answer recruitment queries and create a sense of healthy competition, with every new recruit announced on the channel.

Abbreviation table

Abbreviation	Word in Long
AAGBI	Association of Anaesthetists of Great Britain and Ireland
ACP	Advanced Clinical Practitioner
AP	Assistant Practitioner
ALSG	Advanced Life Support Group
AMHP	Approved Mental Health Practitioner
AMHS	Adult Mental Health Service
ANP	Advanced Nurse Practitioner
APEM	Association of Paediatric Emergency Medicine
APLS	Advanced Paediatric Life Support
ARI	Acute Respiratory Infection
ATMIST	Age and sex, Time of incident, Mechanism of injury, Injuries suspected, Signs and symptoms, Treatment administered
AVPU	Alert, Verbal, Pain, and Unresponsive
AYPH	Association for Young People's Health
BMI	Body Mass Index
BNFC	British National Formulary for Children
BP	Blood Pressure
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Service
CTP	Care and Treatment Plan
CAS	Clinical Advisory Service
CBRN	Chemical Biological Radiological and Nuclear
CCG	Clinical Commissioning Group
CCO	Children's Commissioners Office
CCT	Certificate of Completion of Training
CDOP	Child Death Overview Panel
CHH	Child Health Hub
CMR	Case Management Review
CPA	Care Programme Approach
CPC	Child Protection Committee
CPIS	Child Protection Information Sharing
CPS	Child Protection Services
CRP	C-Reactive Protein
CT	Computed Tomography
CYP	Children and Young People
CYPSAR	Children and Young People Seeking Asylum and Refugees
DCC	Direct Clinical Care
DKA	Diabetic Ketoacidosis
ECDS	Emergency Care Data Set
ECIST	Emergency Care Improvement Support Team
EcLiPSE	Emergency Treatment with Levetiracetam or Phenytoin in Status Epilepticus in Children
ECP	Emergency Care Plan
ED	Emergency Department

Abbreviation	Word in Long
ENP	Emergency Nurse Practitioner
ENT	Ear, Nose and Throat
EPALS	European Paediatric Advanced Life Support
EPRR	Emergency Preparedness Resilience and Response
FBC	Full Blood Count
FGM	Female Genital Mutilation
FII	Fabricated or Induced Illness
FLACC	Face, Legs, Activity, Cry, Consolability pain scale
GAPRUKI	General and Adolescent Paediatric Research in the United Kingdom and Ireland
GCS	Glasgow Coma Scale
GIRFEC	Getting it Right for Every Child
GMC	General Medical Council
GP	General Practitioner
GIRFT	Getting it Right First Time
HAZMAT	Hazardous Materials
HEEADSSS	Home, Education/Employment, Eating, Activities, Drugs, Sexuality Suicide and Safety
ICB	Integrated Care Board
ICM	Intensive Care Medicine
IPC	Infection Prevention and Control
JAR	Joint Agency Response
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and the + is inclusive of all identities and sexualities, regardless of how people define themselves.
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MAPS	Mental Health Admissions to Paediatric Wards Study
MDT	Multidisciplinary Team
MHA	Mental Health Act
MHCYP	Mental Health of Children and Young People survey
MTC	Major Trauma Centre
NAI	Non-Accidental Injury
NAPSTaR	Neonatal, Adult and Paediatric Safe Transfer and Retrieval
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NMTR	National Major Trauma Registry
NSPCC	National Society for the Prevention of Cruelty to Children
OHID	Office for Health Improvement and Disparities
OT	Occupational Therapist
PA	Programmed Activity
PATCH	Providing Assessment and Treatment for Children at Home
PCCS	Paediatric Critical Care Society
PCCTS	Paediatric Critical Care Transport Service
PED	Paediatric Emergency Department
PEM	Paediatric Emergency Medicine

Abbreviation	Word in Long
PERN	Paediatric Emergency Research Network
PERUKI	Paediatric Emergency Research in the UK and Ireland
PEWS	Paediatric Early Warning System
PGDiT	Postgraduate Doctors in Training
PHEM	Pre-Hospital Emergency Medicine
PICU	Paediatric Intensive Care Unit
PIC	Petechiae in Children study
PIER	Paediatric Innovation, Education and Research Network
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
PRSB	Professional Record Standards Body
PRUDiC	Procedural Response to Unexpected Death in Childhood
PTSD	Post Traumatic Stress Disorder
RAT	Rapid Assessment and Treatment
RC	Resuscitation Council
RCEM	Royal College of Emergency Medicine
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCoA	Royal College of Anaesthetists
RCPCH	Royal College of Paediatrics and Child Health
RCPCH &Us	Royal College of Paediatrics and Child Health network of children, young people, parents and carers
RCPsych	Royal College of Psychiatrists
SAS	Specialist, Associate Specialist and Specialty doctor
SBNI	Safeguarding Board for Northern Ireland
SDEC	Same Day Emergency Care
SIDS	Sudden Infant Death Syndrome
SPA	Supporting Professional Activities
SPOT	System-wide Paediatric Observation Tracking
SRP	Scottish Resilience Partnership
STAG	Scottish Trauma Audit Group
STOPP	Safe Transfer of the Paediatric Patient Tool
SUDIC	Sudden Unexpected Death in Infancy and Childhood
ToC	Theory of Change
UEC	Urgent and Emergency Care
UKHSA	United Kingdom Health Security Agency
UTC	Urgent Treatment Centre
WHO	World Health Organisation
WTE	Whole Time Equivalent
YW	Youth Worker

Acknowledgements

RCPCH would like to thank all of the members of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care, without whom the revision of this document would not have been possible.

Scott Hendry	Chair
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Michelle Jacobs	Royal College of Emergency Medicine (RCEM)
Daniel Gooding	Royal College of Nursing (RCN)
Adrian Hayter	Royal College of General Practitioners (RCGP)
Laavanya Damordaran	Royal College of Psychiatrists (RCPsych)
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The Committee would like to extend thanks to the RCPCH &Us team and to the children, young people and families that were involved in developing and consulting on the standards via the RCPCH &Us network.

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

Published October 2025

Royal College of Paediatrics and Child Health
Incorporated by Royal Charter and registered as a Charity in
England and Wales: 1057744 and in Scotland: SCO38299.
Registered Office 5-11 Theobalds Road, London WC1X 8SH.
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