Facing the Future:
Standards for Paediatric Services

April 2011

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

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1. Introduction

All children and young people who require it should receive high quality care, delivered by trained and competent professionals in a timely manner and in appropriate settings. The purpose of this document is to set out a series of service standards that will ensure that such excellent paediatric care is provided.

It is written against a background of a significant financial crisis in the UK, large-scale workforce pressures in many inpatient paediatric units, relatively poor health outcomes for the UK childhood population,[1] and inadequate provision in many aspects of children and young people's healthcare.[2] Given this backdrop, the Royal College of Paediatrics and Child Health (RCPCH) does not believe that to continue as we are is an option. The College must face the future and so we propose what we consider are a set of minimum standards for paediatric services. Whilst the RCPCH has little influence with the current funding problems for the NHS, it has a responsibility and ability to influence the quality of the service that is provided.

In this document the RCPCH specifies ten service standards, all of which have been approved by the College Council. The College considers the standards to represent a minimum requirement for all acute general paediatric services. Each standard is accompanied by an explanatory text that indicates in more detail what the standard is seeking to achieve, and how it will be implemented.

The RCPCH recognises that the implementation of these standards may cause transitional difficulties for some services. However, the rewards of achieving these standards are considerable. All children and young people seen in paediatric departments will receive high quality consultant delivered care,[3] their health outcomes will improve, there will be greater efficiency, and so some of the problems highlighted by Sir Ian Kennedy's report into children's healthcare will be addressed.

In his report, Sir Ian described children and young people's healthcare as a "Cinderella" service. It is the College's view that unless this crisis in paediatric services is addressed the health of children and young people in the UK will continue to suffer and we will not stand by and let that happen.

1. A*n overview of child well-being in rich countries. (UNICEF: 2007)*. Available at unicef-irc.org (accessed 24th April 2010); *Wellbeing and Child Poverty: Where the UK stands in the European Table?* (Child Poverty Action Group, Spring 2009) Available at: cpag.org.uk (accessed 24th April 2010)
2. Kennedy, Professor Sir Ian, *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs* (Department of Health, September 2010) Available at dh.gov.uk (accessed 1st October 2010).
3. Temple, Professor Sir John, *Time for Training: A review of the impact of the European Working Time Directive on the quality of training.* (MEE: May 2010) Available at mee.nhs.uk (accessed 10th July 2010)

2. RCPCH Service Standards

The following section specifies the 10 service standards that the RCPCH believes should be achieved by all acute, general paediatric services. The College considers these standards to represent a minimum requirement and they are all underpinned by the principle that consultants are responsible and accountable for the children and young people admitted under their care. The standards are first listed and then an explanatory guide to each one is provided in the subsequent section.

The standards were developed using a review of the relevant literature and consultation with paediatricians. Three of these standards have already been adopted by the College and published in its manifesto (Standards 1-3). Standards 7,9 and 10 were developed in consultation with the relevant specialist groups and represent consensus decisions. Standards 4,5 and 6 emerged from our review of the literature. Standard 8 is a recommendation of the Academy of Medical Royal Colleges and is partly based on published evidence.

It is the College's intention to initiate a national audit program against these standards in due course.

1. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.**

2. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care), within the first 24 hours.**

3. **Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.**

4. **All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.**

5. **At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).**

6. **A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.**

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

8. **All general acute paediatric rotas are made up of at least 10 WTEs, all of whom are EWTD compliant.**

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

10. **All children and young people. children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.**

Explanatory Guide to Standards

The Temple report concluded that consultant-delivered, as opposed to consultant led or consultant-based, care was the only viable model for the future of medical care in the UK. There were a number of reasons for this but most importantly the simple fact that consultants "make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality."[4] The Temple report defines consultant-delivered care as "24 hour presence, or ready availability" and it is this model of service that underpins many of the service standards.

1. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.**

2. **Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first twenty four hours.**

It is important to recognise that these two standards apply to acute rather than elective admissions, and also they refer to admissions to paediatric departments rather than mere attendance at, for instance, emergency departments. The College would expect doctors on the middle grade rota to be those who are judged to have achieved level 1 competences of the *RCPCH Framework of Competences*. This would normally mean those working in posts at ST4 or above. In units where there are just two tiers of medical cover this will not be possible and the consultant should be resident when it is judged that any member of the tier 1 rota e.g. paediatric trainee, GP trainee or advanced children's nurse practitioner, does not have the basic competences of recognising a sick child and being able to initiate treatment for paediatric emergencies. When a resident rota has trainees of ST1 or ST2, who have not yet achieved level 1 competences, our first service standard would ensure that all children and young people admitted with an acute medical problem would be seen by a paediatrician on the consultant rota within 4 hours of admission.

4. Temple, Professor Sir John, *Time for training*, p41.

If the most senior resident doctor is at ST3 level the College would recommend that

the consultant review takes place within 12 hours of admission rather than 24 hours. The admission time is taken to be the official time of admission to the paediatric department rather than, for instance, the time of presentation to the emergency department or the time of referral to the paediatric department.

For SSASG doctors to be considered as "consultant equivalent" they should successfully revalidate at this competency level through the RCPCH or a similar approved partner scheme. The RCPCH encourages SSASG doctors to develop competencies throughout their career and to take the MRCPCH exam if they wish to do so. The RCPCH also supports the provision of at least 1.5 SPAs each week for SSASGs to have adequate time for CPD and preparation for revalidation. In addition, they must have a mutually agreed named consultant who, at least as part of an annual appraisal process, has assessed them as competent to work on the consultant rota.

The RCPCH recognises that implementation of the second of these standards will need consultant rounds at least once per day, and ideally twice per day, seven days per week. However, the College believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality.[5]

3. **Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.**

In contrast to standards 1 and 2, this standard concerns all children and young people referred for an urgent paediatric opinion whether the source of that referral is general practice, the emergency department or an SSPAU. The RCPCH would expect all children and young people to be seen by personnel with appropriate expertise. However, as a minimum the College would expect all cases to be discussed with a senior doctor or nurse as specified. This standard would preclude a less experienced doctor who has not achieved level 1 competences in paediatrics sending a child or young person home who has been referred by a general practitioner without that child or young person being discussed with a more senior colleague.

Standards 1,2 and 3 were arrived at by consensus during extensive discussions by the RCPCH Council and Executive Committee.

4. **All SSPAUs have access to a paediatric consultant (or equivalent)opinion throughout all the hours they are open.**

The RCPCH is aware that not all SSPAUs have consultant presence during their opening hours. However, studies have shown that the availability of consultants can decrease the rate of unnecessary admissions without compromising patient safety or patient

5. McNeill G et al,'What is the effect of a consultant presence in an acute medical unit?', *Clinical Medicine* (June 2009); 9(3):214-8

satisfaction.[6] Therefore, it is our view that all SSPAUs should have consultants (or SSASG equivalents, see explanatory text to Standards 1 and 2) available for advice even if they are not physically present.

The College also would expect that any child or young person who is continuously present in an SSPAU for more than 8 hours will be discussed with a consultant or paediatrician on a middle grade rota to decide upon ongoing treatment and/or transfer.

Standard 4 is based on published evidence.

5. **At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).**

6. **A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.**

Implementation of the EWTD (European Working Time Directive) and the consequent transition to shift patterns of working have significantly reduced the continuity of care that junior doctors used to provide and increased the number of clinical handovers between medical staff. At the same time, junior medical staff have not always yet adopted the kind of structured handover process with which nurses are familiar. There is a growing body of evidence that clinically significant information can be lost during the handover process, and that this can lead to adverse outcomes for patients.[7] It is also well documented that the peak admission time for acute paediatrics is the early evening, 5-10pm, when traditionally the consultant has not been present. Consultant presence during this time would not only improve patient outcomes, but their presence during handovers would provide an excellent training opportunity for junior staff.[8] Hence, the College has specified these two standards in order both to improve patient safety and outcomes as well as facilitate the training of medical staff.

Standards 5 and 6 are based on published evidence.

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

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

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6. 'Positive impact of increased number of emergency consultants'. Geelhoed G et al, *Archives of Disease In Childhood* (September 2008); 93: 62-4.
7. Borowitz et al, 'Adequacy of information transferred at resident sign-out (in-hospital handover of care): a prospective survey', *Quality and Safety in Health Care* (2008), 17: 6-10; Clark et al, 'The PACT Project: improving communication at handover', *Medical Journal of Australia* (2009); Ye et al, 'Handover in the emergency department: deficiencies and adverse effects', *Emergency Medicine Australasia* (2007), 19:5:433-441; Carter et al, 'Information loss in emergency medical services handover of trauma patients', *Prehospital Emergency Care* (2009), 13:3:280 - 285
8. Temple, *Time for Training*, pp20,35,52.

has indicated that such systems have contributed towards WTD compliance, improved patient safety, created better continuity of care and better training, supervision and consultant support for trainees.[9] The College recognises that some consultant of the week rotas may include some SSASG doctors if recognised as competent to operate at this level (see explanatory text to Standards 1 and 2).

Standard 7 has a pragmatic base, and was arrived at consensually.

8. All general acute paediatric rotas are made up of at least 10 WTEs, all of whom must be EWTD compliant.

The EWTD mandated that no-one should work more than 48 hours per week on average. The subsequent SiMAP[10] and Jaeger[11] judgements have clarified the implications for junior doctors. The Academy of Medical Royal Colleges have stated that in order to protect adequate training time, as well as to cover for annual leave and recovery periods, 10 WTE doctors in a rota are required.[12] It is possible to design rotas that are compliant with just 8 staff and in relation to neonatal medicine, where there is less daytime outpatient activity, rotas of this size may be entirely appropriate.[13] However, for general acute paediatrics, 8 cell rotas inevitably result in the use of internal locums, and therefore in practice are not sustainable. The College does not believe that relying on junior doctors opting out of the directive is acceptable. An exception to this standard would be where resident consultants form part of the middle grade rota. In this situation, rotas with fewer trainees can be appropriate, sustainable and EWTD compliant provided there are the equivalent of 10 WTE's on the rota.[14]

Standard 8 is partly pragmatic, and partly based on published evidence.

9. *Children's and Maternity services in 2009: Working Time Solutions* (RCPCH, RCO&G, 2008). Available at: http://www.healthcareworkforce.nhs.uk (accessed 4th August 2010)
10. http://theCollegebarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Workforceplanninganddevelopment/Europeanworkingtimedirective/DH_4051942 (accessed 20th August 2010)
11. http://theCollegebarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Workforceplanninganddevelopment/Europeanworkingtimedirective/DH_4068970 (accessed 20th August 2010)
12. *Implementing the European Working Time Directive* (Academy of Medical Royal Colleges, 2004). Available at aomrc.org.uk (accessed 30th April 2010). See also Ahmed-Little, Y, Bluck, M, 'The European Working Time Directive 2009', *British Journal of Health Care Management* (2006) 12:12 pp374-376.
13. *Service Standards for Hospitals Providing Neonatal Care* (BAPM, August 2010)
14. *Delivering Safe Services: Consultant Delivered Care for Maternity, Paediatric and Neonatal Services* (Teamwork Management Services, 2008). Available at: healthcareworkforce.nhs.uk (accessed 13th August 2010). The College do also acknowledge that it is possible to design a compliant middle grade rota comprised of 7 trainees, and the equivalent of 2 consultants.

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

With increasing centralisation of specialist care and in order to facilitate appropriate long term condition management closer to the child or young person's home, it is imperative that local paediatricians have access to appropriate specialist advice in a timely manner, at least if unnecessary referrals and admissions are to be avoided. This standard aims to ensure that the local paediatrician, whether based in the community, an SSPAU or an inpatient unit, can access the specialist opinion that is needed when faced with acute problems in children and young people with complex and specialist needs. It is optimal if such advice is provided as part of a managed clinical network which encompasses all of the local secondary care providers. It is also important to stress that this standard does not apply when the presenting problem is not an emergency, nor does it apply to referrals from non-paediatricians who should, in the first instance, seek the advice of their local paediatric service.

Standard 9 was arrived at by consensus.

10. **All children and young people, children's social care, police and health teams should have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.**

Standard 10 aims to ensure that any child or young person of 17 years or younger, presenting with child protection concerns, is appropriately assessed at an appropriate time by a competent paediatrician. This service must be available to all units on a 24/7 basis. As with all clinical presentations, the timing of the assessment is determined by the presentation and in child protection, the likelihood of finding and collecting forensic evidence.

An initial strategy discussion (with interagency colleagues) must take place in accordance with local safeguarding policies, as soon as practical and usually within 2 hours. Depending upon the needs of the child or young person (clinical, forensic and safety) the child or young person must be assessed and an opinion provided (which may be provisional depending upon further investigations and discussion) usually within 12 hours of presentation where there are recent injuries. The written medical document should be available within 3 days.

Specialist paediatric and forensic opinion should be available to all units within 4 hours for all acute sexual assaults and all unexpected child deaths. Paediatricians should act as the "single point of contact" for children's social care departments to articulate the concerns of the medical professionals involved with the family. They should attend initial and review conferences whenever there is likely to be a discussion of the interpretation of medical views or findings.

Standard 10 was arrived at by consensus.

3. Conclusion

At the start of this document, it was acknowledged that the current state of children and young people's healthcare in the UK is not adequate. Sir Ian Kennedy's recent report has highlighted a series of concerns about the way children and young people's healthcare is delivered. This document and series of service standards represents our first marker in the ground. Given the relatively poor health outcomes of our childhood population, we simply cannot ignore the problems before us anymore.

We have set out a series of service standards that we consider to be a minimum for acute, general paediatric services. This document is a first in a series of publications. Subsequent ones will explore the implications that these standards have for the configuration of paediatric services and the paediatric medical workforce. We also intend to develop standards for some subspecialty services. Our intention with them all is to fulfill our remit to set standards of safety and quality in an attempt to help raise the standards of care that are currently delivered to our children and young people. When adopted, these standards will ensure that children receive high quality, safe and sustainable healthcare whenever and wherever it is needed.

The College cannot implement these standards without the support and commitment of our members. We accept that some services may have difficulties in achieving all of the standards. However, if we believe that these standards will ensure a safer and better healthcare system for children and young people, we must ensure that all paediatric services are progressively developed to achieve them. The standards call for a greater degree of consultant presence than has hitherto been the case, and this will inevitably mean changes in working practices for some consultants. However, the College believes that adherence to these standards will bring a necessary level of consistency to what is currently quite a variable pattern of practice, and in the process ensure that every child or young person that warrants it receives appropriate review in a timely manner by a suitably experienced doctor.

We therefore do not just draw our members' attention to these standards, but also the government (including those of the devolved nations), commissioners and health boards, and NHS managers for it is their responsibility to ensure that the framework is in place for clinicians to work effectively and safely. It is imperative that some means to improve the quality of children and young people's healthcare is found and the College believes that the standards in this document represent a realistic opportunity to do just that.

Our vision is one where all children and young people who require it receive timely and appropriate care in settings as near as possible to their home delivered by well-trained and competent professionals. If the standards in this document are implemented then it is a vision which in due course could be realised and for that reason we commend them to our members.

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