



Facing the Future: Standards for children in emergency care settings

June 2018

Facing the Future: Standards for children in emergency care settings

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

Representative bodies:

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

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Understand &Us

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

Their top tips using the word 'Understand' are:

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



For more information about the Children and Young People's Engagement Team at the RCPCH and how we include children and young people's voice in the work of the College, please contact and_us@rcpch.ac.uk or by calling 020 7092 6076/6079.

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Introduction

The landscape of urgent and emergency care provision for children has changed significantly in recent years and continues to evolve at pace, albeit with much complexity and variation across the UK. The demands on emergency and urgent care provision for children continue to rise for reasons that are multifactorial²⁻⁴. What is apparent is a need for the system to be simple, accessible and responsive to the needs of local communities. Infants, children and young people deserve the highest quality assessment and treatment in all urgent and emergency settings. Together we must strive to get things right for some of our most vulnerable patients.

In light of the 'Five Year Forward View', 'The Right Time, The Right Place' and the 'Keogh Review of Urgent and Emergency Care Services' and 'National Unscheduled Care Essential Actions Improvement Programme', work has begun across the UK to address these required changes^{2,5-7}.

At a time of transition into new models of care, it is particularly pertinent for providers and service planners to work together to meet standards to ensure locally delivered, safe and high quality urgent and emergency care for infants, children and young people.

This document, brought together using the expertise of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings builds on previous editions. We acknowledge the challenges facing paediatric urgent and emergency care by providing standards that support, inspire and motivate clinicians to provide the highest quality care for all children, wherever they present.

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Chair of the Intercollegiate Committee for Standards for Children and Young People in
Emergency Care Settings

Purpose and Scope

Facing the Future: Standards for children in emergency care settings document provides healthcare professionals and service planners with clear standards of care that are applicable to children in urgent and emergency care settings.

They are intended to be motivating, meaningful and measurable with evidence, guidance and metrics accompanying each standard to support implementation. Services will be able to measure their progress using the metrics provided and accompanying audit toolkit.

Key terms and definitions

| | |
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| Children / ICYP | Infants, children and young people under the age of 18 across the UK*. |
| Parents and carers | Those who hold parental responsibility but who may not be the biological parent. |
| Paediatric Emergency Medicine Consultant (PEM) | A Paediatrician Emergency Medicine consultant (often referred to as PEM consultant) is a doctor who specialises in the initial assessment and management of children presenting with a wide range of undifferentiated conditions to urgent and emergency care settings. These doctors will have completed sub-specialty training in paediatric emergency medicine and have a training background in either paediatrics and/or emergency medicine. Training is regulated by both the RCPCH and RCEM. |
| Urgent and emergency care settings | The range of healthcare services available to children who need medical advice, diagnosis and/or treatment quickly and unexpectedly. |
| SSPAU | A hospital-based facility in which infants, children and young people with acute illness, injury or other urgent referrals from clinicians can be assessed, investigated, observed and treated with an expectation of discharge in less than 24 hours. |

* Children over the age of 18 may be seen in paediatric urgent and emergency care settings if their needs are not met in adult services.

Executive Summary

Complete list of standards for children in emergency care settings.

| Standard | Page |
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| An integrated urgent and emergency care system | |
| 1. Urgent and emergency care services are planned, commissioned and delivered through clinical networks. | 21 |
| 2. The care of ICYP in integrated urgent care centres is planned and delivered using these standards to meet the needs of children. | |
| 3. Staff receiving children in urgent care centres have the appropriate paediatric competence to provide immediate assessment. | |
| Environment in emergency care settings | |
| 4. Emergency care settings are designed and provided to accommodate the needs of children and their parents/carers. | 26-27 |
| 5. All emergency departments that treat children employ a play specialist. | |
| 6. Children, young people and their parents/carers are invited to provide feedback on the service received in the urgent and emergency care setting to inform service improvement. | |
| 7. Children and their parents/carers must be provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand. | |
| 8. Patient flow models which consider patient acuity and consultation time are used in planning capacity of the built environment. | |
| Workforce and training | |
| 9. Every emergency department treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics. | 31 |
| 10. Every emergency department treating children must be staffed with two registered children's nurse. | |
| 11. A minimum of two children's nurses per shift in dedicated children's emergency departments must possess recognisable post-registration | |

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| trauma and emergency training. | |
| 12. Every emergency department treating children must enable their staff to attend annual learning events that are specific to paediatric emergency medicine. | |
| 13. Every emergency department treating children must have a member of staff with APLS (or equivalent) training on duty at all times. | |
| 14. Every emergency department treating children must have their qualified staff trained in infant and child basic life support (BLS). | 30 |
| 15. PEM consultants should have adequate Supporting Professional Activities in a full time job plan in which to continue their own development and that of the trainees. | |
| Management of the sick or injured child | |
| 16. All children who are streamed away from an emergency care setting must be assessed by a clinician with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters including basic observations. | |
| 17. All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs. | |
| 18. A system of prioritisation for full assessment is in place if the triage waiting time exceeds 15 minutes. | |
| 19. Children with abnormal vital signs at initial triage assessment have their observations repeated within 60 minutes. | |
| 20. Every emergency department treating children has an established Early Warning System. | 39-41 |
| 21. Policies in place for the escalation of care for critically unwell children. | |
| 22. The appropriate range of drugs and equipment is available for facilities receiving unwell or injured children. | |

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| 23. Analgesia is dispensed for children with moderate and severe pain within 20 minutes of arrival to the emergency department and pain score is reassessed and acted upon within 60 minutes. | 39-41 | |
| 24. Registered practitioners treating children in the emergency department deliver health promotion and accident prevention advice that is recorded in discharge summary notes. | | |
| 25. Discharge summaries are sent to the child's GP and other relevant healthcare professionals within 24 hours of their attendance to the emergency department. | | |
| 26. Emergency ambulatory care teams work with community services to promote and develop prevention to hospital admissions. | | |
| Safeguarding in emergency care settings | | |
| 27. All staff who regularly look after children must have up to date safeguarding children training and competence in line with the <i>Intercollegiate Document</i> ⁸ | 45-46 | |
| 28. All emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding. | | |
| 29. All emergency care settings have guidelines for safeguarding children. | | |
| 30. All staff in emergency care settings have access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. | | |
| 31. Information from the Child Protection Plan is available to staff in emergency care settings. | | |
| 32. Systems are in place to identify children and young people who attend frequently. | | |
| 33. The primary care team, including GP and health visitor/school nurse and named social worker, are informed, within an agreed timescale, of each attendance. | | |
| 34. A review of the notes is undertaken by a senior doctor or nurse when a child leaves or is removed from the department without being seen. | | |
| 35. When treating adults, staff must recognise the potential impact of a parent's | | |

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| or carer's physical and mental health on the wellbeing of dependents, and take appropriate action, including when domestic abuse is suspected. | | |
| 36. Implementation of nationally approved information sharing systems (such as the Child Protection Information Sharing (CPIS) system in England) is occurring as per contract. | 45-46 | |
| 37. Policies are in place to review cases where ICYP either leave or abscond from a department unexpectedly prior to discharge or when they do not attend for planned follow up. | | |
| 38. ICYP at high risk of potential safeguarding presentations are reviewed by a senior (ST4+) paediatrician or PEM doctor. | | |
| Mental health | | |
| 39. All ICYP presenting to a children's ED have a developmentally appropriate assessment of their immediate emotional and mental health needs. | | |
| 40. A documented risk and capacity assessment should be done for all patients presenting in mental health crisis and this process should commence at triage. | | |
| 41. Adequate and appropriate space is available for children/families in crisis and should include safe space with suitable supervision by emergency staff. | | |
| 42. There is access to mental health records and development of individual crisis plans for each CYP seen and assessed in mental health crisis in the ED. | 51-52 | |
| 43. A clear system is in place with service planners to escalate care of patients who require Tier 3 (+) in-patient care. | | |
| 44. Emergency clinicians with responsibility for the care of children receive training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity. | | |
| 45. Telephone availability of paediatric mental health practitioner 24hours a day, 7 days a week, for advice and able to attend for assessment when appropriate | | |

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|---|-------|--|
| 46. Policies are in place for the management of an acutely distressed child or young person incorporating the use of acute tranquilisation and, as a last resort, restraint for those who are acutely disturbed or at risk of harm to themselves or others. | 51-52 | |
| 47. When CYP require access to a mental health in-patient bed but there is a delay >4 hrs, they are looked after in a suitable paediatric facility with appropriate in-patient facilities, regular CAMHS review, trained registered mental health nurses and paediatric nursing support. | | |
| 48. There is a clear pre-identified pathway for patients on a Section 136 order for an identified place of safety to meet their medical and mental health needs. | | |
| Children with complex medical needs | | |
| 49. Triage systems must consider the additional requirements of prioritising care for children with complex medical needs. | 57 | |
| 50. When treating a child with complex medical needs, the need to consider early escalation for senior review should be included in all training and induction. | | |
| 51. When treating a child with complex medical needs, staff should ask to see the child's emergency care plan. | | |
| 52. The needs of children with complex medical needs must be considered within the planning and design of the emergency department. | | |
| 53. Where electronic alerts are available these must be used to signpost to relevant information such as emergency care plans or the requirement for an early senior assessment. | 57 | |
| 54. Information about the child or young person's attendance to an emergency care setting should be shared with the relevant professionals involved with them, including the lead clinician. Links should also be established with local specialist nurse and community children's nursing team to ensure effective follow-up care and support. | | |
| Major incidents involving children and young people | | |
| 55. The needs of children must be included in the strategic and operational planning and delivery of preparing and responding to major incidents. | | |

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| 56. Children, paediatric medical staff and nursing staff must be involved routinely in appropriate incident exercises with the relevant safeguards in place. | 61 |
| Safe transfers | |
| 57. Each region has a Paediatric Critical Care (PCC) Transport team, provided, managed and governed by it's Paediatric Critical Care ODN. | 66 |
| 58. The regional PICU has a dedicated, 24-hour transfer helpline, for critically ill or injured children, providing clinical support and advice, and co-ordinating paediatric retrievals and transfers. | |
| 59. Local facilities have appropriate staff and equipment readily available, for "time-critical" transfers. | |
| 60. ED staff trained in stabilisation and transfer of paediatric patients. | |
| 61. Parents and families of children transferred between hospitals are given practical help and information detailing their child's transfer destination. | |
| Death of a child | |
| 62. All emergency departments caring for children have local agreed policies in place for responding to the unexpected death of a child. | 72 |
| 63. Children that have died outside of the hospital setting are taken to a hospital with paediatric facilities*. | |
| 64. All emergency departments caring for children provide training to staff on how to support carers/parents in response to an unexpected death. | 72 |
| 65. Co-operation with the Rapid Response Team and Child Death Overview panel to ensure learning is shared between agencies. | |
| Information system and data analysis | |
| 66. All emergency care practitioners treating children in the urgent and emergency care network have information systems that provide basic demographic and episode related information. | |
| 67. All health organisations providing emergency care to children must collaborate with national information centres (i.e. NHS Digital) to involve and inform of the needs of patients, clinicians, managers and service | |

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|--|------|--|
| planners/commissioners in developing emergency care information systems. | 78 | |
| 68. All emergency departments treating children collect performance data that is used to improve services locally and to benchmark performance nationally. | | |
| 69. Emergency departments treating children adhere to Emergency Care Discharge Summary Standard. | | |
| Research for paediatric emergency care | | |
| 70. All emergency departments treating children have a nominated lead for paediatric emergency research with PERUKI membership. | 80 | |

Current challenges in urgent and emergency care

Expectation and demand

Children and young people are more frequent users of emergency departments than adults⁹. Worryingly, the number of emergency admissions for infants has risen alongside rises for short-stay admissions for children and young people^{10,11}. Year on year the number of children presenting to the emergency department with minor ailments increases by 5%¹². Cuts to public health and social care budgets will no doubt be attributing to already fragmented out-of-hospital care for children, which may explain why children attend the emergency care setting more frequently than the adult population¹³.

Whilst the emergency department is, for many children and families across the UK, the 'front-door' to access health services, several reports have shown that parents prefer to seek advice from their General Practitioner (GP)^{14,15} and tend to do so an average of six times per year for children under four years of age¹⁶. Widening access to GPs would have a major impact on relieving pre-hospital urgent care pressures. Practices whose patients report better access also have 10% fewer visits (2500 per year) to emergency departments¹⁷. A significant proportion of families that end up in emergency departments have already sought review by another healthcare professional that reflects an inappropriately high number of referrals from one healthcare provider to another for young children¹⁸⁻²⁰. The RCPCH Facing the Future: Together for Child Health standards aim to ensure that specialist child health expertise is available at the front end of the care pathway, strengthening the role of primary care services in order to reduce the burden on urgent and emergency care services³. However, since 2004, large scale policy change in primary care in the community reduced access to GPs has been associated with higher rates of children's hospital admissions for ambulatory care conditions²¹. No child should be in hospital where care can be provided to an equivalent or better standard outside the hospital and closer to home if appropriate.

NHS England's key commitment for emergency healthcare is to ensure attendances to major emergency departments are seen, admitted or discharged within four hours. The Quality Watch has reported that 125 out of 138 major emergency departments were unable to meet the four hour waiting time target in August 2017²² and attendances to major centres in England increased significantly (32%) between 2003 and 2013²³. Similar rises in attendance has been reported in Scotland, Wales and Northern Ireland²⁴⁻²⁶.

Northern Ireland has the highest percentage of patients breaching four hour waits (28%), with over 1 in 10 children attending its major children's hospital in 2016 staying for longer than four hours²⁶. Although more generally across the UK the four-hour standards are more

readily achieved for children, the important measures for this population are quality and safety of care.

The current urgent and emergency care system is confusing and fragmented and a significant proportion of children who present to emergency departments with low acuity conditions can be managed in the community^{4,10,27-29}. A study in Scotland has shown that whilst the number of paediatric emergency admissions has steadily increased year on year, the number of emergency admissions discharged on the same day rose by 186% between 2003 and 2013³⁰. The poor organisation of services is as likely to put pressure on urgent and emergency services as the health-seeking behaviours of those attending³¹.

Telephone Triage Advice Services (NHS111 in England, NHS 24 in Scotland, NHS Direct in Wales and GP out of hours in Northern Ireland)

Analysis of telephone advice services from NHS111, a service in England set up to address urgent care pressures on emergency departments, shows that there is high use among young children with common conditions³². For under five year olds, the largest proportion of presentations to emergency care were the result of a small spectrum of common conditions, trends of which have remained unchanged for a decade^{18,33}. Despite advice to seek GP review, significant numbers still attend emergency services. Linking urgent and emergency care service data with out-of-hours general practice could help to identify opportunities to improve quality and efficiency of services locally³².

Mental health

The number of children attending the emergency department in crisis is rising and a report undertaken by the Care Quality Commission in 2017 has highlighted the complex and fragmented provision of mental health services for children³⁴. Multiple organisations providing mental health services can lead to confusion and barriers in access and in 2015, 28% of children were turned away from CAMHS upon referral³⁵. Access to specialist mental health services varies widely across regions in the UK, and whilst no direct link has been evidenced, increasing referrals and waiting times to CAMHS may be contributing factors to the increase in children attending emergency departments^{13,34}.

The government's commitment to invest £54 million to support child mental health provision between 2014 and 2020 was superseded by further cuts to health care and doubts have been raised as to whether funding has been effectively received³⁶. In 2016, children under 16 years old spent a total of 1,657 days on adult wards, breaking the duty of care

stated under the Mental Health Act 2007³⁷. There are significant capacity issues within mental health provision and an investment to provide more inpatient beds for children with mental health needs is essential in order for children to be cared for in a suitable setting by appropriately skilled staff.

Children are increasingly attending urgent and emergency care centres with emotional and behavioural crisis that falls outside of the care provided by CAMHS. Ensuring staff working in emergency care settings have the right skills to recognise when children require mental health services in addition to the right social care services (or other agencies) supporting children outside of the hospital setting will help to reduce the burden on emergency care.

Long-term conditions / complex needs

The number of children with long-term condition and/or complex needs is increasing³⁸. The child with complex needs can pose a particular assessment and diagnostic challenge in the early stages of illness or injury. Many will have a mild self-limiting condition, but may present with signs consistent with more serious disease, or vice versa.

Expertise, safety netting and the ability to observe children for a period of time are critical to providing safe care³⁹. Easy access across the network to community nursing teams and paramedics with enhanced competencies who can provide assessment and treatment at home, or to paediatric emergency departments or paediatric short-stay assessment units is pivotal to supporting a whole urgent care system that is safe and effective^{29,40}.

Children with complex care needs are predominantly managed in the community and sometimes limited access to community services may lead to unscheduled attendance to the hospital.

Workforce pressures

Despite an increase in the numbers of trained paediatric emergency medicine consultants in the UK, evidence from the RCPCH Medical Workforce Census reports that 50% of units do not have a paediatric emergency medicine consultant working in the emergency department⁴¹. It is encouraging to see this addressed with the Royal College of Emergency Medicine reporting a steady rise in emergency medicine trainees completing sub specialty training in paediatrics and similarly a rise in RCPCH trainees completing emergency sub specialties^{42,43}.

We know that GPs often do not have the necessary paediatric competence to assess and manage children in the primary care setting and *RCPCH Facing the Future: Together for Child Health* standards have aimed to address this. Evidence from the Facing the Future

Audit 2017 reports that 86.2% of GPs are able to access immediate telephone advice from a consultant paediatrician for children with unscheduled care needs⁴⁴. This helps to ensure paediatric expertise is at the front of the care pathway for children requiring same-day care.

Chapter 1: An integrated urgent and emergency care system

The future of urgent and emergency care for children is dependent upon building whole system networks that harness expertise within the subspecialty of paediatric emergency medicine that links across all urgent care and community settings. Developing robust care pathways, building capability amongst professionals (such as GPs, health visitors, pharmacists and paramedics), and providing seamless links via intuitive governance and information sharing platforms will enable children to be managed by the right person, in the right place, at the right time and as close to home as is possible and safe to do so.

Building on what already works

To achieve a sustainable future for the health service, innovative new models of care must be developed and implemented^{5,6}. Children's services have delivered ambulatory care for well over a decade, and a robust infrastructure now exists for this in several areas, compared with many other specialties. Progress is however hindered by silos in which services have evolved. The success of integrated care requires collaborative commissioning, development of rotational clinical posts, and the ability to think beyond organisational turfs toward networked pathways of care which transcend barriers.

Specialists in paediatric emergency medicine and acute paediatric care should continue to provide a hub of specialist clinical advice and support across local networks that are supported by critical care and acute transport services. Clearly defined pathways to access sub-specialist services such as surgery, cardiology and others are also essential. Robust protocols should exist within local ambulance services to ensure critically ill and injured children are conveyed to the most appropriate hospital, by-passing if necessary those nearby in favour of those with the right expertise and resources to manage them. Much can be learnt from Major Trauma Networks, now well established across England and in development in other parts of the UK.

Further integration between acute and community services is required to ensure sustainability in urgent and emergency care provision. There are successful examples across the UK of both working together to develop acute community nursing teams with assessment skills enabling children that previously would have been admitted to hospital to be cared for at home^{3,45}. Closer working between GPs and consultant paediatricians as part of local 'child health hub' may have potential to increase the capacity of GPs in managing paediatric patients, reducing outpatient referrals and emergency department attendances, and building relationships locally to promote safe and effective delivery of care in the community⁴⁶.

New models of care

The whole system approach

Organising urgent and emergency care services through clinical networks will ensure clear mechanisms for communication are in place to enable services to plan, deliver and share service arrangements across a large population.

Networks need to be established between primary, secondary and tertiary care providers. The network must include specialist paediatric emergency departments, non-specialist emergency departments, acute paediatric units, GP surgeries, GP out of hours services, urgent care centres, minor injury units and community services including community nursing teams, pharmacists, ambulance services, telephone triage advice services (NHS111 in England, NHS 24 in Scotland, NHS Direct in Wales and GP out of hours in Northern Ireland), health visitors and school nurses.

All should work together to develop a seamless pathway that manages children in the most appropriate setting according to their needs, and as close to home as possible when safe to do so. The *Facing the Future: Together for Child Health* standards set out detailed guidance for the care of children and young people with acute illness outside the hospital³.

It is essential that every emergency department has an integrated urgent care centre to ensure children receive the right care, at the right time, in the right place. Urgent care centres will help to support the operational delivery of emergency care and aim to reduce admissions to the emergency department. Children attending urgent care centres must be greeted with a clinician with appropriate paediatric competence (see Chapter 3 for guidance).

Aligned with NHS England's Five Year Forward View, work has begun to modernise and improve urgent and emergency care services.

Pathways

Networks should encompass the whole pathway; from families receiving pre-emptive advice from health visitors around self-care of minor illnesses right up to the safe management of a critically ill or injured child requiring specialist care. To ensure children journey smoothly through the urgent and emergency care system, it is imperative to establish simple, locally agreed care pathways for common conditions which transcend the whole

"Increasing local knowledge of what is available, what the referral pathway is and identifying where there are gaps or changes to pathways and communicating these quickly will help to improve services."

RCPCH &Us® Voice Bank 2016

urgent and emergency care system, in and out of hospital³. These pathways and the infrastructure of the local system need to be clear, simple and well publicised by commissioners, planners and providers so that families can make informed choices as to how, where and when to seek care. Local networks should collaborate on developing such pathways and regularly review processes to improve quality and enhance efficiency.

To be truly 'whole system', the resourcefulness of families and communities should not be overlooked. Child health professionals need to be proactive in supporting parents and carers to self-manage in their home environment to avoid unnecessary trips to healthcare providers. Clear and consistent safety netting needs to be delivered to ensure that the child does not suffer and is signposted to the most appropriate service if self-care becomes unmanageable.

Service planners, commissioners and providers

Commissioners/service planners and providers need to support, encourage and enable cross boundary and organisational working. Such collaborative commissioning needs to be resolute in addressing the challenges of perverse financial incentives, clinical and information governance, and information sharing. Learning from other sectors and being adaptive and responsive to local needs rather than adopting a one-size-fits-all approach is required to achieve successful sustainable change in service design that is fit for purpose⁴⁷.

Training and Information Systems

It is vital to ensure the provision of adequately trained staff across the whole system. Ensuring staff have the adequate paediatric competence and the infrastructure in place to ensure information sharing is accessible across all settings will ensure a seamless pathway of care for children. See chapter 3 for Staffing and Training and Chapter 9 for Information Systems.

Patient Flow

Better patient flow reduces congestion and over-crowding in emergency departments, but it requires whole system planning and agreed care pathways for common conditions³. Guidance is available for how to collaborate services across health and social care systems⁴⁸.

| Standards | Metrics |
|---|---|
| 1. Urgent and emergency care services are planned, commissioned and delivered through clinical networks. | <ul style="list-style-type: none"> • Documented meetings attended by service planners, commissioners and service providers to plan urgent and emergency services across organisational and geographic boundaries. • Evidence of quality assurance and service evaluation processes across the urgent and emergency care network. • Evidence of shared care protocols and guidelines. |
| 2. The care of ICYP in integrated urgent care centres is planned and delivered using these standards to meet the needs of children. | <ul style="list-style-type: none"> • Audit of Facing the Future: Standards for children in emergency care settings (2018). |
| 3. Staff receiving children in urgent care centres have the appropriate paediatric competence to provide immediate assessment. | <ul style="list-style-type: none"> • Evidence that staff receiving children in urgent care centres have the appropriate paediatric competence to provide immediate assessment (e.g. via appraisal and training compliance). |

Practice Example

Royal Derby Hospital Paediatric Observation Unit (POU)

The number of short stay paediatric assessment units being established is steadily growing (7.2% increase between 2013 and 2015) and accounts for the largest change in paediatric service provision in the UK⁴¹. The RCPCH Medical Workforce Census 2015 reported that 50.3% of units do not have paediatric emergency medicine consultants working in the emergency department at all. The Royal College of Emergency Medicine has reported on a steady increase of emergency medicine trainees completing sub-specialty accreditation in paediatrics⁴², and this will be an essential trend if we are to deliver safe, effective and timely care to children receiving treatment in emergency care settings. SSPAUs are increasingly recognised as vital in helping deliver early senior review and are hubs for emergency ambulatory care.

The Paediatric Observation Unit at the Royal Derby Hospital is open 9am–2am, seven days a week and is co-located with the Children’s Emergency Department. Children attending the POU must be under 17 years of age with an anticipated discharge within eight hours of admission to the POU.

The single front door policy means that all children come to the Children's Emergency Department to be triaged, treated and prepared either for inpatient admission, observation in the POU or discharged home. Patients are admitted to the POU under the duty Children's Emergency Department Consultant. Once a bed has been booked, the transfer to it should occur within 20 minutes. Children should have a clear admission plan, discharge criteria and any investigations should be done prior to admission to the POU.

Nurse-led discharge can occur according to certain pathways. Children and their families are given an idea of the time and circumstances around their discharge at the time of admission, with regular updates as necessary. If the patient is identified at any time to need onward inpatient admission the reason for this must be clearly stated in the notes and discussed with the parents. A consultant is resident until 11pm, at which time they carry out a ward round to decide plans for remaining patients ahead of the POU closing at 2am each night.

The POU has at least one nurse in charge at all times (supported by nurses in the Children's Emergency Department), with additional help from an allocated healthcare assistant. A consultant is resident from 9am to 11pm with access to a consultant available during all opening hours (from 11pm to 2am this is via the general paediatric consultant on-call).

Since the opening of the POU, admissions to the inpatient ward have fallen from 16% to 12% and with the recent extension of the POU opening hours to 2am this has fallen further to 8.9%. The average length of stay is 150 minutes (range: 23 minutes to 11 hours).

More details: Dr Gisela Robinson, Royal Derby Hospital gisela.robinson@nhs.net

Chapter 2: Environment in emergency care settings

All urgent and emergency care settings accepting children and young people should be designed to accommodate their needs and those of their accompanying parents, carers and siblings. All grades of staff coming into contact with children and young people should be skilled in communicating with them at an appropriate level; guidance is provided by the General Medical Council (GMC)⁴⁹. Children should be involved in discussions and decisions about their care, which should be tailored to their needs and wishes as far as possible in an atmosphere which promotes dignity, privacy and respect.

Parents will generally be anxious, and must have an opportunity to share their concerns and questions swiftly. Families may be juggling priorities such as the care of other children and their practical needs should also be met such as food and drink for the children, or breastfeeding, nappy-changing, and bottle-warming facilities.

Built environment

In general, children's treatment areas require more space per patient than adult areas to accommodate medical equipment, floor space for the child, toys, and space for family members. Children usually prefer being in a larger waiting room with more space to being in a cubicle and emergency departments treating children must provide dedicated secure space for parking buggies or pushchairs.

There should be sufficient child-friendly clinical cubicles or trolley spaces to meet the need of your paediatric population including at times of peak attendance. It is recommended that detailed patient flow models are used, taking into account patient acuity and consultation time in planning. Children should be provided with waiting and treatment areas that are separate from adult waiting areas⁵⁰. The needs of bereaved parents or carers should also be accommodated with private areas in which to view their child, meet with professionals, and accommodate additional family members. Children's areas should be monitored securely and zoned off with access control to protect children from harm, including the ability to contain someone who may want to leave the department against clinical advice.

The minimum requirement for urgent and emergency care settings treating children includes the following:

1. Designated, appropriately designed waiting room for children and young people with space for parents/carers and buggies
2. Designated areas suitable for breastfeeding and nappy changing

3. Appropriate safe area for children with mental health needs⁵¹ (e.g. a ligature free environment that may involve removing furniture and equipment)
4. A cubicle with a door for consultations where privacy and confidentiality is paramount
5. Facilities for the full resuscitation and also monitoring of high dependency children, as well as those treating more minor illnesses/injuries
6. A route to the imaging department which avoids other areas of the emergency care setting if possible

Children's wards which are used for the initial reception of emergency admissions must be appropriately staffed by clinicians with the appropriate paediatric competence and equipment, and must have a monitored high dependency area in order to receive, triage, manage and resuscitate children⁵⁰.

Useful recommendations on the built environment in England and Wales can be found in the NHS Estates Health Building Note (HBN) 15-01: *Accident & Emergency Planning and Design and Design Guidance*⁵², HBN 23: *Hospital Accommodation for Children and Young People*⁵³ and the NHS Wales publication *Friendly healthcare environments for children and young people*⁵⁴. Urgent and emergency care departments must ensure the clear signposting to toilets, changing facilities, disabled access and routes to the emergency department.

Facilities

The atmosphere and furniture of the children's area (including reception, waiting and treatment areas) should be accessible, welcoming and child-friendly⁵⁰. There should be a range of recreational activities appropriate for children and young people of different ages; these should be refreshed regularly, and may have separate areas for different age ranges. Local charities, donors or media campaigns often assist with this. Murals, mobiles, posters and colourful decoration help allay anxiety and make clinical assessment and treatments much easier.

"We don't feel comfortable in the ED"

"The entrance area is confusing and the waiting room is boring and not for our age."

RCPCH &Us® Voice Bank 2016

Play is essential for children's holistic development and is a universal right for all children⁵⁵. For ill and chronically ill children, play can offer many additional health benefits which can enhance their physical, social, emotional and mental wellbeing⁵⁶. Every department caring for children must have access to a play specialist service. In smaller departments play services may be shared with in-patient services and for larger departments, a play specialist must be recruited full-time. Provision must be made for children with multiple needs, learning differences and disability, to support the inclusion of every child⁵⁷.

The role of a play specialist in emergency care settings includes⁵⁷⁻⁵⁹:

- providing distraction therapy for potentially distressing procedures
- enhancing nursing and medical skills to involve play in the management of procedures in children
- maintenance of a child-catered environment, including advising on safe and appropriate toys and facilities
- supervision of play in the department
- advising on the requirements of children with special needs

Wherever possible, consideration should be made for older age groups and there should be clear arrangements for accommodation of young people for whom neither the children nor adult area may be appropriate^{60,61}. Young people may prefer quieter, more private, surroundings with age-appropriate games/entertainment.

Information and communication

Information, including written advice leaflets, web resources and health apps about common conditions must be available and appropriate to the child's age and language and that of their parent/carer. Children and their parents/carers must be provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand³. If the setting discharging the child or young person is not open 24 hours, verbal and written instructions should be given on how the family should access further advice, if necessary.

Families using urgent and emergency services are often experiencing stress as a result of their visit and staff must work to support children and parents/carers during their visit. Campaigns such as 'Hello my name is' encourage open dialogue with families and are important during every patient contact⁶².

Emergency care settings should use the opportunity to offer wide-ranging advice for young people's wellbeing including accident prevention and health promotion including signposting to the relevant and accessible resources.

Access to phone translation services must be available 24 hours a day, seven days a week and consideration must be given to the appropriateness of parents/carers translating, especially when discussing concerns around safeguarding.

Involvement

Children, young people and their parents/carers must be involved in providing feedback of their experience in the urgent and emergency care setting. In doing so, services are able to identify areas for improvement that can prompt changes to improve quality. The RCPCH has developed a range of resources and guidance available to improve children and young people involvement in health services⁶³. Children and their parents/carers must be consulted during significant service change and service planning⁶⁴.

“Things get lost in translation (when parents speak for you)”

RCPCH &Us® Voice Bank
2017

To help better understand care from children’s experience and perspective, the RCPCH and the Picker Institute developed a template for a Patient Related Experience Measures (PREMs) for urgent and emergency care in children⁶⁵. Organisations and service planners should utilise the PREM tool to provide feedback for improvement of services both locally and across a network.

| Standards | Metrics |
|--|--|
| <p>4. Emergency care settings are designed and provided to accommodate the needs of children and their parents/carers.</p> | <ul style="list-style-type: none"> • Evidence of compliance with the <i>You’re Welcome</i>⁶¹ quality criteria for services in England (standards are under review and being piloted as of 11-5-2018) • Evidence of compliance with the Department of Health Building Note 15-01⁶⁶ (HBN 23⁶⁷ for larger units) • Provision of an appropriate waiting room and treatment rooms for children and young people, including the availability of food and drink, age appropriate games, music or films, breast-feeding areas and hygienic safe play facilities. • The provision of at least one clinical cubicle or trolley space for every 5,000 annual child attendances dedicated to children. • Evidence of involvement of the voice of children, young people and their parents/carers in service design and delivery. |

| Standards | Metrics |
|---|---|
| <p>5. All emergency departments that treat children employ a play specialist.</p> | <ul style="list-style-type: none"> • Evidence of play specialist on duty, or access to play specialist service. |
| <p>6. Children, young people and their parents/carers are invited to provide feedback on the service received in the urgent and emergency care setting to inform service improvement.</p> | <ul style="list-style-type: none"> • Evidence of the mechanism or facility available for patients/parents and carers to deliver feedback. |
| <p>7. Children and their parents/carers must be provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.</p> | <ul style="list-style-type: none"> • Evidence that verbal safety netting information is provided. • Evidence that written safety netting information is provided. • Evidence that other formats of information are provided. • Evidence that the child and parent/carer understands the information being provided. |
| <p>8. Patient flow models which consider patient acuity and consultation time are used in planning capacity of the built environment.</p> | <ul style="list-style-type: none"> • Evidence of patient flow models within planning capacity of the built environment. |

Chapter 3: Workforce and training

Paediatric Emergency Medicine

Paediatric Emergency Medicine (PEM) is a subspecialty which has recognised training pathways to Consultancy through both the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Emergency Medicine (RCEM). The existence of such training and of the Association of Paediatric Emergency Medicine (APEM), have resulted in enhanced paediatric emergency care throughout the UK & Ireland⁶⁸.

During their training programs, PEM trainees learn all facets of paediatric emergency care. There are significant benefits from having this dual-college approach to training, as those trained in each route have complementary strengths. These training programs produce consultants who possess the unique skill set required for paediatric emergency care, which cannot be replicated simply by having a mix of emergency and paediatric clinicians. They are specialists in undifferentiated presentations, with expertise in paediatric medical, surgical and traumatic conditions. Beyond clinical interactions, they are also skilled in safeguarding, patient flow, team working, leadership, communication, and interfacing with primary care and inpatient teams.

The benefits of having PEM consultants in emergency departments are therefore manifold, whether in enhancing PEM skills and knowledge, or in other areas such as reducing hospital admission⁶⁹. Since the introduction of Standards for Children and Young People in Emergency Care settings, there has been a rapid and sustained growth in PEM consultant numbers, and in trainees pursuing this as a career. A 2013 survey showed a 10-fold increase in PEM consultants over the preceding 10 year period, though with striking geographical variation per capita across England and Wales that highlights the majority of consultants are attracted to working in larger urban centres⁷⁰. It is clear that this variation must be reduced, and that paediatric emergency care of the highest standard should be delivered nationally, rather than in small pockets, or isolated in larger centres.

This has also reflected an ongoing rise in the number of clinicians undertaking this training, and an increase in the number of training centres⁴². Since 2006 the number of PEM trainees has risen 5-fold, with approximately 50 trainees in post in any calendar year. All training centres are subject to a quality assurance program to ensure that the standard of training is of a high calibre. PEM trainees are provided the opportunity to develop all the key clinical and non-clinical skills (including an extended set of PEM specific skills such as procedural sedation and point of care ultrasound) during their program.

Nursing

Delivery of high quality holistic paediatric emergency care of course extends beyond

physicians. Recent years have seen increases in the number of nurse practitioners looking after children in emergency departments. Nursing staff play a key role in the delivery of care to children and, like clinicians; they often come from both paediatric and emergency care backgrounds. Emergency departments treating children must be staffed with two registered children’s nurses⁷¹. A minimum of two children’s nurses in dedicated children’s emergency departments must possess recognisable post-registration trauma and emergency training. This brings added strength to the emergency department as the skill mix is complementary in raising the standard of care. Increasingly, emergency nurse practitioners with paediatric skills and nurses with advanced emergency care skills are a vital part of the workforce. It is recognised that recruiting nurses with appropriate skills is increasingly challenging. Developing a flexible nursing workforce with both paediatric and adult emergency care skills, for example with appropriate rotational training, is key (especially in smaller units).

“Having workers with you like play or youth workers is important to help you through it.”

RCPCH &Us Voice Bank 2018

Allied health professionals and non-clinical personnel are key to having well rounded emergency departments for children. These include play specialists, health visitors, social workers, clerical staff and increasingly, liaison youth workers.

Training and workforce requirements

All emergency departments treating children should have at least one PEM trained consultant, though numbers of PEM consultants should be greater than this in larger emergency departments. Consultants in a PEM role should fulfil all the requirements of the RCPCH/RCEM curricula and syllabi for PEM subspecialty training.

Table 1: Number of trainees recommended for PEM subspecialty accreditation as of March 2018

| Year of CCT | RCEM | RCPCH |
|-------------|----------|----------|
| 2012 | 10 | 6 |
| 2013 | 23 | 11 |
| 2014 | 17 | 7 |
| 2015 | 15 | 7 |
| 2016 | 22 | 7 |
| 2017 | 19 | 11 |
| 2018 | 4 so far | 1 so far |

In order to be able to focus on PEM clinical and non-clinical duties (including training and governance), individuals should have dedicated direct clinical care sessions in PEM, though many will likely have some participation in acute paediatric or adult emergency care, depending on the staffing compliment of the whole department. The time for PEM should be ring-fenced at an individual and departmental level.

PEM consultants should have adequate Supporting Professional Activities in a full-time job plan in which to continue their own development and that of the trainees. This should include time for learning (with at least some attendance at collaborative PEM network events) and for other activities including governance, research, clinical effectiveness, performance and quality improvement. Administrative duties should be recognised as direct clinical care, and any job plan should reflect the predictable and unpredictable nature of paediatric emergency care on-call work.

Emergency Departments delivering PEM training must do so at the level stipulated by the RCPCH and RCEM training committees. This training should cover clinical and non-clinical domains, and enable trainees to fully appreciate the role of a PEM consultant by the end of training. Training programs should be dynamic, with protected time for consultants to deliver teaching and work place based assessments, and should have protected time for trainees to learn in line with service delivery. Training in PEM should be rewarding for the trainee and the department, resulting in improved safe and efficient care of children which can be carried forward into future placements. Trainees 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.

There should be regular collaborative learning events across PEM networks that aim to nurture working relationships, address operational and governance issues and ensure a consistent standard of clinical knowledge and skills across the system. Community teams require robust links with specialist paediatric emergency and acute paediatric teams. Urgent care centres need to link with their local paediatric emergency department for learning, training and safety netting. With increasing numbers of private providers for urgent care centres co-located with emergency departments, there is a continued requirement to ensure development of clear standards to encourage collaboration and quality improvement in the name of optimising safe and high-quality care. Specialist paediatric emergency departments, acute paediatric and short stay paediatric assessment units (SSPAUs) teams are a pivotal part of orchestrating and providing this teaching and education³. These training events should be available to all staff from hospital, urgent care, and primary care settings who see acutely ill or injured children, including all grades of training and non-training grade medical staff, nurse practitioners, nurses, and allied health professionals.

Staffing levels and skill mix of nursing staff are just as crucial in the effective emergency care of children. These must be an appropriate level to respond to surges in attendance, or

the unpredictable arrival of the morbidly ill or major trauma patient – all while continuing to care for patients throughout the rest of the emergency department.

| Standards | Metrics |
|---|--|
| 9. Every emergency department treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics. | <ul style="list-style-type: none"> • Provision of PEM consultant in every emergency department • Increase of trainees enrolling onto PEM training. |
| 10. Every emergency department treating children must be staffed with two registered children's nurses. | <ul style="list-style-type: none"> • Evidence of two children's nurses on shift (e.g. audit of rota). |
| 11. A minimum of two children's nurses per shift in dedicated children's emergency departments must possess recognisable post-registration trauma and emergency training. | <ul style="list-style-type: none"> • Evidence of children's nurses on shift in dedicated children's emergency department with relevant qualifications in trauma and emergency care. |
| 12. Every emergency department treating children must enable their staff to attend annual learning events that are specific to paediatric emergency medicine. | <ul style="list-style-type: none"> • Number of professional development training hours accrued each year. |
| 13. Every emergency department treating children must have a member of staff with APLS (or equivalent) training on duty at all times. | <ul style="list-style-type: none"> • Evidence of staff member with APLS (or equivalent) training on duty at all times (e.g. audit of rota and training logs). |
| 14. Every emergency department treating children must have their qualified staff trained in infant and child basic life support (BLS). | <ul style="list-style-type: none"> • Audit of training logs. |
| 15. PEM consultants should have adequate Supporting Professional Activities in a full time job plan in which to continue their own development and that of the trainees. | <ul style="list-style-type: none"> • Evidence of SPAs in job plans for PEM consultants. |

Practice Example

Training and workforce at Sheffield Children's Hospital

Sheffield Children's Hospital has an emergency department which sees over 55,000 children a year. It provides placements for trainees from both RCPCH and RCEM in paediatric emergency medicine (PEM) and as such is constantly looking for ways to improve its training experience. Like other departments it suffers from staffing shortages and has looked for ways to address this. A programme has been developed training several of the Band 7 nurses in the department to be advanced nurse practitioners, with a particular focus on injury management that allows them to see children independently, request X-rays and initiate management plans. They function at the tier one level and contribute hugely to patient flow in the department. There is also a departmental study budget for nursing staff to facilitate training and development.

There are spaces on the rota for paediatric trainees to rotate through the emergency department in recognised training roles, giving experience of paediatric emergency medicine to a wider cohort of trainees who may not otherwise have considered the specialty as a career path. A high proportion of these trainees go on to apply for PEM subspecialty training. Trainees in the department attend the regional training for paediatric or emergency medicine trainees as well as departmental teaching sessions, which are run three times in order to maximise access for less than full time trainees and shift workers. As the number of PEM trainees is usually small, they are supported to arrange teaching sessions in collaboration with fellow trainees from nearby centres, improving networking and training experience, and providing access to a much wider range of specialists and training opportunities. They are also encouraged to participate in regional networks such as the North of England Paediatric Emergency Medicine Network. A zero hours locum is employed to cover junior doctor training and there is a cover week built into the tier one rota to allow study leave and attendance at regional teaching.

Real benefits to trainees have been seen in the last four months with the introduction of a GP to the department in the evenings. Approximately 10% of patients are streamed to primary care, reducing the low acuity workload so trainees are seeing a higher proportion of more unwell and complex patients. There is also an additional consultant available between 3pm and 7pm which has resulted in closer supervision of trainees and more workplace based assessments being completed. A 15 minute teaching session has been introduced to the afternoon handover thus making handover a teaching tool as well as a patient safety measure.

One workforce innovation that has been hugely beneficial is the introduction of a paediatric liaison nurse. This is a role created to improve the departments safeguarding procedures. Any doctor who sees a child and has any concerns, which may not be sufficient to raise safeguarding proceedings but needs sharing with other health professionals, can send a message to paediatric liaison and they will share information with the relevant health visitors and GP practices. The liaison team also check for recurrent attenders or anyone

known to social services and ensure appropriate action has been taken. This ensures no child slips through the gaps. Feedback on these referrals is received by emergency department staff at a monthly safeguarding peer review meeting.

More details: Dr Helen Stewart, ST8 Paediatric Emergency Medicine
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RCPCH Resource:

Paediatric Care Online

PCO UK provides immediate access to clinically assured information to inform decisions at the point of care, together with supporting reference material and patient information. The powerful search function offers quick access to critical information using the latest semantic search technology. PCO UK includes Key Practice Points (KPPs), decision support tools that cover common signs and symptoms and critical care situations. Concise and easy-to-use, KPPs are designed to assist healthcare professionals with diagnosis and treatment management at point of care.

Access: www.pcouk.org

Chapter 4: Management of the sick or injured child

Initial assessment

As the demand for urgent and emergency care has continued to rise, many emergency departments are now streaming patients to different care settings either within the emergency department (which may include primary care type services) or both within and even outside of the hospital setting. Children are usually streamed directly to the children's emergency department where they are more fully assessed by appropriately qualified staff. If children are to be streamed or redirected to alternative care settings they must be assessed by an appropriately qualified practitioner with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters including basic observations⁷².

Urgent and emergency care settings must ensure that all children and young people with undifferentiated illness or injury are assessed by competent staff trained in the assessment of children.

All children and young people must be visually assessed by a doctor or nurse immediately upon arrival to identify any unresponsive or critically unwell or injured children requiring immediate attention. All children and young people should receive an initial assessment within 15 minutes of arrival or registration⁷³. A rapid system of prioritisation must be implemented when the wait time to initial assessment exceeds 15 minutes. The initial assessment should be a brief triage assessment conducted by an appropriately trained nurse or doctor with paediatric competence and should follow a standardised system (e.g. The Paediatric Manchester Triage System⁷⁴) supplemented with a pain score and a record of vital signs. Assessment during the urgent or emergency attendance should also include assessment of child protection or at-risk status (see chapter 5).

The receiving area of any emergency care setting should never be left unattended by clinical staff, since critically ill children are often brought unexpectedly by car, rather than by ambulance. All new arrivals must be greeted and kept in view while waiting, so that a deteriorating or critically unwell child can be identified immediately. The RCPCH safe system framework provides online resources and tools to support staff and families in spotting the sick child⁷⁵.

Receiving a child

When a child is received, all staff should routinely explain who they are and what service they can or cannot provide for the patient. *You're Welcome* standards states that: “*Young people [should] not [be] asked any potentially sensitive questions where they may be overheard for example in the reception, waiting areas, ward environment*”⁶¹. All children and young people must be treated in an appropriate area with their privacy and dignity respected. See chapter 2 for more guidance.

Vital signs

All infants, children and young people presenting with a medical illness or significant trauma should have a set of vital signs recorded to include temperature, respiratory rate, heart rate, blood pressure, oxygen saturation Glasgow Coma Scale (GCS) or alert voice pain unresponsive (AVPU) and capillary refill time^{76,77}. An Early Warning System that identifies abnormal vital signs must be used. The RCPCH safe system framework for children at risk of deterioration recommends the use of Paediatric Early Warning charts or Track and Trigger Tools that are especially useful for children who require admission for ongoing observation and treatment and provides links to resources with example tools and standards for measuring and monitoring vital signs⁷⁵. Any children with abnormal vital signs should be prioritised accordingly and the concerns of their parents considered.

Initiating treatments and investigations

Nurses should be trained in initiating relevant treatments, initial care plans (such as oral fluid challenges or administration of analgesia) and investigations (including imaging or preparing a child for likely blood investigations) so these can be initiated at an early stage in the care pathway.

Analgesia and pain scoring

Pain should be assessed at initial assessment using an appropriate pain score, and analgesia for moderate and severe pain delivered within 20 minutes of arrival⁷⁸. Pain should be reassessed appropriately after receiving the first dose of analgesia and supplemented as required, with play-specialist support if needed⁷⁸. Particular emphasis should be given to children and young people who cannot express their pain because of age, illness, injury or disability. Where appropriate, children should be provided with the resources to enable them to make informed choices regarding pain relief management; where possible the child's view should be central to the decisions made about their pain relief⁶¹. Protocols should be in place for the assessment and management of pain in children and the effectiveness of pain management audited yearly⁷⁸. The Royal College of Nursing and Royal College of Emergency Medicine provide pain assessment guidelines including valid tools for

measuring pain intensity in children, including those children and young people with cognitive impairment^{78,79}.

Mental health

Children and young people presenting with mental health or behavioural problems should be triaged according to their clinical as well as their situational urgency. Assessment tools to assist staff in identifying at risk patients should be utilised subsequently and should supplement the formal triage assessment (see chapter 6).

Pre-agreed pathways

For some children with long-term conditions, pre-agreed pathways can provide details for the immediate management, treatment plans and agreement over which team will care for the child. Patient held information, such as emergency passports, can provide additional information that should be considered when prioritising and managing the child.

Children with life-limiting conditions

Parent held and local policies or 'advanced care plans' for children with life-limiting conditions should be in place to ensure care in the emergency department is tailored to their individual needs.

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 triage⁸⁰. Any child with abnormal vital signs identified at triage should have these observations repeated within 60 minutes or earlier for serious conditions⁷⁶. An Early Warning System that detects abnormal vital signs should be used to provide early warning of deterioration to aid the early identification and escalation of care of any children, including those with potential sepsis⁸¹. The Paediatric Observation Priority Score (POPS) is the most validated tool for the assessment of children and young people in emergency and acute settings in the UK⁸². It can be used by paediatric trained and non-paediatric practitioners and has been demonstrated to be effective at recognising acutely unwell children, as well as supporting safe discharge decisions.

Work is underway between the RCPCH, NHS England and NHS Improvement to establish the fundamentals of paediatric early warning score solutions for England.

All facilities receiving sick or injured children should have an appropriate range of drugs and equipment, including that which is required for resuscitation⁸³. A useful checklist of drugs

and equipment for areas receiving acutely unwell and injured children and young people can be found on the Resuscitation Council UK website⁸⁴. Drugs and equipment should be checked in accordance with local policy.

Point of care testing should be available for any emergency environment receiving sick or injured children. These should include, but not be limited to: blood glucose, blood gases, lactate, electrolytes⁵⁰. Emergency CT imaging must be available within an hour of request, 24 hours a day.

Emergency departments must have protocols in place for:

- Resuscitation and stabilisation including clinical guidelines for management of acutely unwell and injured children
- Protocols on how to alert the paediatric resuscitation team or paediatric trauma team
- Composition of the paediatric resuscitation team and paediatric trauma team
- Policies for escalation of care of the deteriorating child (see chapter three)
- Arrangements for accessing support for difficult airway management
- Care of parents during resuscitation of a child⁵⁰.

Parents, carers and children should be supported throughout their attendance. Parents and carers should be updated regularly on their child's condition and management plan. Their views, and views of their child should be sought and used when making decisions about a child's care.

Health promotion in the emergency department

The emergency department is uniquely placed as both a receiving area for children with illnesses and injuries and a highly credible source of health information. It is therefore an ideal setting to empower children, young people and their families about primary accident prevention and health promotion. Health promotion in Emergency Departments ranges from accident and injury prevention advice, providing health information including sexual health, screening programmes and immunisation⁸⁵ and is supported in the context of health sectors providing health promotion in conjunction with clinical services by the World Health Organisation⁸⁶.

“Children and young people felt that [health promotion] messaging should start as early as possible. Families need to be supported to become informed on a range of topics of their local area family services directory so they know where to access support.”

RCPCH &Us® Voice Bank 2016

The urgent and emergency care setting provides opportunities to promote and share information on healthy lifestyle choices with vulnerable young people in addition to signposting to resources and services. Emergency departments are effective when they work with youth support teams with an aim of reducing violence and aggression^{87,88}.

Safe discharge from emergency care settings

Some children will deteriorate after discharge. ‘Safety nets’ must therefore be in place, clinical governance systems applied, and monitoring of outcomes performed. The family must always be advised to return if their child’s condition deteriorates: verbal and written early warning signs of problems and what do to if these occur must be explained in a form that is accessibly and that they understand³. For safe discharge, the environment to which a child or young person is being discharged must be taken into account, particularly if there are issues around supervision, safeguarding, or the ability to return to the emergency care setting easily.

Clinical practice guidelines for any condition must include parameters for safe discharge; for example, ensuring that a child with abnormal observations is not discharged without discussion with a senior doctor. Children presenting for a second time with the same illness or injury within 72 hours should not be discharged without review by a consultant or designated decision maker. Similarly, infants under 12 months of age presenting with a febrile illness should not be discharged without consultant or designated decision maker⁸⁹. In environments where a consultant may not be present, such as Urgent Care Centres,

discussion of the child’s case may be conducted over the telephone and referral to a paediatric centre initiated when appropriate.

Emergency ambulatory care should ensure that children are actively managed at home with the necessary support from community child health services in order to prevent admission to the emergency department⁴⁰. There should be multidisciplinary working with Children’s Community Nursing Services to support admission prevention and continued care at home³.

Notification of attendance must be sent to the child’s primary care team (GP and health visitor or school nurse)⁹⁰, together with any other professionals involved in the child’s care as per local arrangements within 24 hours³. This information should be given both to the child or young person and parents or carers. The community teams must have systems in place to collate information on attendances from different urgent care providers. A liaison health visitor can be employed to assist with communication to the community and/or screen attendances for child welfare concerns.

| Standards | Metrics |
|--|---|
| <p>16. All children who are streamed away from an emergency care setting must be assessed by a clinician with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters including basic observations.</p> | <ul style="list-style-type: none"> • Evidence of qualified practitioner with paediatric competences streaming children. |
| <p>17. All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs.</p> | <ul style="list-style-type: none"> • Audit evidence of the percentage of children who are visually assessed by a registered practitioner immediately upon arrival • Audit evidence of the percentage of children who undergo an initial clinical assessment within 15 minutes of arrival. • Audit evidence of a record of pain score for all children presenting with illness or injury and full record of vital signs for all children presenting with illness. |
| <p>18. A system of prioritisation for full assessment is in place if the triage waiting time exceeds 15 minutes.</p> | <ul style="list-style-type: none"> • Evidence of an escalation policy for prioritisation in place for full assessment if the triage waiting time exceeds 15 minutes. |

| Standards | Metrics |
|---|--|
| 19. Children with abnormal vital signs at initial triage assessment have their observations repeated within 60 minutes. | <ul style="list-style-type: none"> Evidence of compliance with the Royal College of Emergency Medicine Vital Signs in Children audit or similar local audit. |
| 20. Every emergency department treating children has an established Early Warning System. | <ul style="list-style-type: none"> Evidence of use of an Early Warning System. |
| 21. Policies in place for the escalation of care for critically unwell children. | <ul style="list-style-type: none"> Evidence of the policy. |
| 22. The appropriate range of drugs and equipment is available for facilities receiving unwell or injured children. | <ul style="list-style-type: none"> Compliance with equipment listed in Resuscitation Council UK 'Quality Standards for Cardiopulmonary Resuscitation Practice and Training'⁸⁴. |
| 23. Analgesia is dispensed for children with moderate and severe pain within 20 minutes of arrival to the emergency department and pain score is reassessed and acted upon within 60 minutes. | <ul style="list-style-type: none"> Evidence of compliance with the Royal College of Emergency Medicine Pain in Children audit⁹¹ or similar local audit. |
| 24. Registered practitioners treating children in the emergency department deliver health promotion and accident prevention advice that is recorded in discharge summary notes. | <ul style="list-style-type: none"> Evidence of health promotion advice recorded in discharge summary notes. |
| 25. Discharge summaries are sent to the child's GP and other relevant healthcare professionals within 24 hours of their attendance to the emergency department. | <ul style="list-style-type: none"> Evidence of processes in place to ensure discharge summaries are sent to the child's GP within 24 hours of attendance. |

| Standards | Metrics |
|--|--|
| 26. Emergency ambulatory care teams work with community services to promote and develop prevention to hospital admissions. | <ul style="list-style-type: none"> • Evidence of guidelines or pathways to prevent emergency presentations or to promote community-based care with disposition back home rather than hospital admission. • Evidence of collaborative meetings held to prevent hospital admissions. |

Practice Example

E-Resus Whiteboards at Bristol Children's Hospital

The Bristol Children's Hospital Emergency Department sees around 40,000 children per year. The resuscitation area contains three trolleys and two resuscitaires in an intuitively laid out space, designed with input from the multi-disciplinary team to ensure equipment is readily to hand. A family room is located immediately off the resuscitation area so families can be close to their child whilst also having a dedicated quiet space to have their child's care and onward management discussed with them in private.

A key innovation by the Bristol Children's Emergency Department team has been the incorporation of E-Resus, a touch screen electronic whiteboard in every bed space. Designed with a multi-app entry homepage, E-Resus allows the team caring for the most critically sick and injured children immediate access to key guidelines and algorithms of the management of medical emergencies and trauma; access to drug calculators which calculate the exact doses of most of the commonly used intensive care drugs and infusions, thus reducing drug errors; and access to WHO checklists such as Rapid Sequence Induction for anaesthesia to be readily available to support an increase in patient safety during procedures.

E-resus is easy to set up and simple to use. Using Microsoft PowerPoint as a platform and a touchscreen with clearly signposted buttons, clinicians are directed to summarised protocols, guidelines and standard operating procedures. Each button uses a hyperlink connecting to subsequent pages in the PowerPoint presentation or to a web address from an open browser page. Interested trainees and junior clinical staff at Bristol add to the resource list with senior content editing to ensure governance remains tight.

E-Resus has been evaluated in the award-winning Bristol Children's Emergency Department simulation training sessions, demonstrating improved confidence among junior clinical staff in accessing information quickly and among nursing staff preparing drugs and therapies in stressful clinical scenarios.

Facing the Future: Standards for Children in Emergency Care Settings

University Hospitals Bristol **NHS**
NHS Foundation Trust

Paeds E-resus

- All guidelines
- Resuscitation Guidelines
- Medical emergencies
- Trauma
- A-Z Index
- PICU drug sheet
- Medusa
- Emergency contacts
- Distraction

Paeds E-resus guidelines index

University Hospitals Bristol **NHS**
NHS Foundation Trust

Medical Emergencies

- Anaphylaxis
- Antibiotic guidelines
- Asthma
- Bradycardia
- Bronchiolitis
- Croup
- DKA
- Hypercyanotic spells (Fallot's)
- Septic Shock
- Status epilepticus
- Tachycardia
- TOXBASE

Paeds E-resus guidelines index

EMERGENCY INDUCTION CHECKLIST

| Prepare Patient | Prepare Equipment | Prepare Team | Prepare for difficulty |
|--|---|--|--|
| <ul style="list-style-type: none"> □ Is preoxygenation optimal? □ Is the patient's position optimal? □ Can the patient's condition be optimised any further before intubation? □ How will anaesthesia be maintained after induction? | <ul style="list-style-type: none"> □ What monitoring is applied? <ul style="list-style-type: none"> □ ECG □ Blood pressure □ Sats probe □ Capnography □ What equipment is checked and available? <ul style="list-style-type: none"> □ Self-inflating bag □ Suction □ ET tubes □ Laryngoscopes □ Bougies □ Do you have all the drugs required, including vasopressors? | <ul style="list-style-type: none"> □ Who is ...? <ul style="list-style-type: none"> □ Team leader □ First Intubator □ Second Intubator □ Cricoid Pressure □ Circulator's Assistant □ Drugs □ MALS (if indicated) □ How do we contact further help if required? | <ul style="list-style-type: none"> □ If the airway is difficult, could we wake the patient up? □ If the intubation is difficult, how will you maintain oxygenation? (Plans A,B,C,D) □ Where is the relevant equipment, including alternative airway? □ Are any specific complications anticipated? |

This Checklist is not intended to be a comprehensive guide to preparation for induction. ©2019

Paeds E-resus RSI checklist **Difficult airway guidelines**

Many thanks to Dr Chris Bryden, Specialist Trainee in Paediatric Emergency Medicine, and Dr Rachel Sunley, Consultant in Paediatric Emergency Medicine, for their help with this practice example.

More details: Rachel Sunley, Paediatric Emergency Medicine Consultant, University Hospitals Bristol Rachel.Sunley@UHBristol.nhs.uk.

Chapter 5: Safeguarding in emergency care settings

Safeguarding encompasses promoting the welfare of children, protecting children from maltreatment, preventing impairment of children's health or development, and ensures children grow up in safe circumstances. Child protection is part of safeguarding and refers to activities undertaken to prevent children suffering, or likely to suffer from significant harm⁹⁰.

Emergency Departments may be the first point at which children who have been subjected to abuse or neglect come into contact with professionals who are able to act for their protection. Therefore, there is a clear need for health professionals to both protect infants, children and young people who present with suspected abuse or neglect and retain an active role in seeking to prevent abuse.

All health care organisations are legally required to make arrangements to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm. Each nation has published guidance setting out the duties and expectations of staff in urgent and emergency care settings^{90,92-94}. Other essential guidance for staff working in emergency settings include the NICE guidance Child maltreatment: when to suspect maltreatment in under 18s⁹⁵, the General Medical Council (GMC) child protection guidance Protecting children and young people: the responsibilities of all doctors⁹⁶ and the RCPCH Child Protection Companion⁹⁷, available through Paediatric Care Online UK⁹⁸.

Identifying and reporting safeguarding concerns

It is crucial that all staff in emergency and urgent care settings can identify children and young people who are or may be at risk of abuse or neglect. Identification involves the early recognition of vulnerable children and young people, targeting support for the most vulnerable and being clear about how and where help can be accessed. As well, there should be clear protocols on what to do when abuse or neglect is suspected. Protocols should be relevant and specific to each unit, and include information on how to access advice and what actions to take when welfare concerns are identified. Staff should also be prepared to reflect on interactions with children and young people and amend practice to ensure a child-focused approach.

There should be a system in place to allow staff to swiftly identify children who have been the subject of repeated emergency attendance and/or advice telephone calls from emergency or other unscheduled healthcare settings, and whether the child is subject to a

Child Protection Plan or registered on the Child Protection Register. These cases should be examined at regular intervals and appropriate action taken which may include exploration of the causes for repeat attendance with the multidisciplinary team.

Children with known special or extra needs, such as asylum-seeking children, children with disabilities and those who are looked after or in the criminal justice system, should also be identified on arrival to the department. Likewise, systems must be in place in all emergency care settings to review cases where children and young people leave before being assessed or are not brought back for follow-up.

Staff should be particularly aware of families with complex and multiple problems. Parental factors such as substance misuse, domestic abuse and mental health problems can indicate that children living under these circumstances are at an increased risk of harm. As such, there should be close liaison between adult and children's emergency departments in recognising, assessing and reporting child safeguarding issues when adult patients with dependent children present with these concerns. Staff in children's emergency departments should be proactive in facilitating these interactions to help protect children.

Aside from the more common forms of abuse and neglect, those caring for children must also be trained to recognise different forms of abuse which may occur, such as child sexual exploitation, fabricated or induced illness⁹⁹, gang-related and peer violence, human trafficking¹⁰⁰, domestic abuse¹⁰¹, forced marriages and crimes perpetrated in the name of honour. The Home Office recommends that all professionals interacting with children undertake 'Prevent' training that aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves¹⁰². Similarly, undertaking training to recognise female genital mutilation (FGM)¹⁰³ is vital in order to fulfil health professional's mandatory duty in England and Wales to report known cases of FGM in under 18-year-olds to the police¹⁰⁴.

Sharing of information

Robust systems are required to inform the primary care team about each child's attendance at an emergency care setting. This should include the GP, community midwife, health visitor or school nurse.

There must also be a focus on sharing information securely between local authorities and NHS trusts in order to better identify children who are subject to a child protection plan and looked after children when they present to unscheduled care 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 unscheduled care settings¹⁰⁵. It is endorsed by the Care Quality Commission (CQC) and NHS organisations are expected to have begun work towards implementation, as per the NHS Standard Contract. Where electronic systems are not enabled, it is essential that all staff know the procedures

for determining the child protection status of any child or young person attending the department.

The police should also be informed promptly when a child or young person presents with a wound caused by a gun, or from an attack with a knife, blade or other sharp instrument¹⁰⁶. Recognition and referral of young people with injuries caused from peers, through fighting, or by being attacked is good practice. Increasingly, children's emergency departments have embedded specialist liaison youth workers who can provide follow up and support by working with young people to reduce the behaviours putting them at risk of injury.

Sharing of information can be enhanced by appointing a liaison health visitor. The role and scope of the work of the liaison health visitor varies, but must be matched to the number of children requiring safeguarding, the availability of the settings' named doctor and named nurse for safeguarding, and the availability of information from social services.

Staffing and training

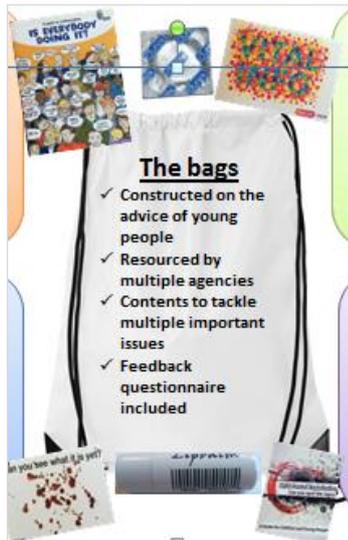
All emergency care settings should have a clinical lead and senior nurse with responsibility for child protection and all staff working in emergency care settings should have access to training and ongoing supervision in child protection appropriate to their role. Detailed requirements are contained within the intercollegiate safeguarding competences⁸ and summarised in chapter four.

| Standards | Metrics |
|--|---|
| 27. All staff who regularly look after children must have up to date safeguarding children training and competence in line with the <i>Intercollegiate Document</i> ⁸ | <ul style="list-style-type: none"> Staff training logs demonstrating compliance. |
| 28. All emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding. | <ul style="list-style-type: none"> Evidence of a lead consultant and a lead nurse is included within the services Standard Operating Procedure document. |
| 29. All emergency care settings have guidelines for safeguarding children. | <ul style="list-style-type: none"> Evidence that guideline is available and accessible. |
| 30. All staff in emergency care settings have access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. | <ul style="list-style-type: none"> Evidence of access within the Child protection rota. |

| Standards | Metrics |
|--|---|
| 31. Information from the Child Protection Plan is available to staff in emergency care settings. | <ul style="list-style-type: none"> Evidence of how and when to access duty social worker is included in the Standard Operating Procedure document. |
| 32. Systems are in place to identify children and young people who attend frequently. | <ul style="list-style-type: none"> Electronic system that records attendance frequency. |
| 33. The primary care team, including GP and health visitor/school nurse and named social worker, are informed, within an agreed timescale, of each attendance. | <ul style="list-style-type: none"> Evidence that discharge summaries are sent to the GP and health visitor/school nurse and named social worker. |
| 34. A review of the notes is undertaken by a senior doctor or nurse when a child leaves or is removed from the department without being seen. | <ul style="list-style-type: none"> Case note audit. |
| 35. When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action, including when domestic abuse is suspected. | <ul style="list-style-type: none"> Evidence is included in induction and training. |
| 36. Implementation of nationally approved information sharing systems (such as the Child Protection Information Sharing (CPIS) system in England) is occurring as per contract. | <ul style="list-style-type: none"> In England, CPIS is implemented. |
| 37. Policies are in place to review cases where ICYP either leave or abscond from a department unexpectedly prior to discharge or when they do not attend for planned follow up. | <ul style="list-style-type: none"> Policy available to all staff. Case note audit. |
| 38. ICYP at high risk of potential safeguarding presentations are reviewed by a senior (ST4+) paediatrician or PEM doctor (e.g. infants who are non mobile presenting with injuries such as bruising, burns or fractures.) | <ul style="list-style-type: none"> Case note audit. |

Practice Example

Adolescent Grab Bags, Best Practice Examples from North Middlesex University Hospital



The North Middlesex University Hospital is the busiest paediatric emergency department 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 Emergency Department to deliver key information on vulnerabilities including child sexual exploitation, sexual health (including LGBT+), drugs, alcohol, mental health, gangs and knife crime. The 'grab bags' are one strand of a larger bi-borough

multiagency 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 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.

"It feels good that you are trying to reach young people."

Comment from Grab Bag Evaluation Questionnaires

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

Many thanks to Jessica Salkind and Josephine Ellis for their help with this practice example.

More details: Dr Gayle Hann, Paediatric Emergency Consultant and Named Doctor for Child Protection, North Middlesex University Hospital gayle.hann@nhs.net

Chapter 6: Mental health

Around one in 10 children experience mental health problems in the UK¹⁰⁷. The largest population cohort committing acts of self-harm are those aged between 11 and 25 years old¹⁰⁸. In 2017, the Prime Minister requested the Care Quality Commission undertake a review of children's mental health services. Findings revealed a complex and fragmented system with multiple providers and minimal coordination in the delivery of services³⁴. Consequently, children, families and their GPs struggle to access timely and appropriate support, resulting in exacerbation of symptoms, increased use of emergency routes as a way of accessing more timely Child and Adolescent Mental Health Services (CAMHS) involvement and a general lack of faith in being able to get help when needed. Recent Royal College of Psychiatrists' (RCPsych) research has revealed that mental health trust income in 2018 is lower than it was five years ago¹⁰⁹. Further RCPsych analysis of the NHS Digital workforce data showed that as few as 3.75 child and adolescent psychiatrists are employed per 100,000 children in one Health Education England region, with only 17.32 / 100,000 children in the most well-endowed urban area, and that there has been a 6.3% decline in child and adolescent psychiatrists since 2013¹¹⁰. All these issues have compounded difficulties in young people accessing timely mental health care.

Emergency care settings often represent the first point of contact for vulnerable children who are seeking help in a crisis. Ideally, children should be recognised by effective mental health services within community settings before they reach emotional or behavioural crisis point in emergency settings. However, the majority of CAMHS operate Monday to Friday 9 am – 5pm, with varying out of

hours services in place, and shared rotas covering multiple sites. Therefore, it is essential for staff working in urgent and emergency care settings to have the right skills and competence to be able to identify children presenting with mental health needs. Developing and maintaining strong links between emergency departments and children's CAMHS and social care services is important in order to ensure that appropriate and timely CAMHS and social care support is available for children in crisis.

Children can present in emergency department settings for a range of reasons, including: mental health issues, substance misuse and self-harm. Providing appropriate care for these children can be a challenge within an emergency care setting, which primarily focuses upon treatment for physical illnesses. Lengthy waiting times in urgent and emergency care environments often mean that children with mental health presentations are not seen in a timely manner¹¹¹. Though no direct link has been evidenced, increasing referrals and waiting times to CAMHS are viewed by most working in this field as key contributors to the

"It's important with mental health that you know who will get you the help."

RCPCH &Us Voice Bank 2018

increasing number of children attending emergency departments; children are waiting an average of 33 days for assessment and 56 days for the initiation of treatment in CAMHS^{13,112}.

Challenges for urgent and emergency care staff

It is essential for staff working in urgent and emergency care settings to have the right skills and attitude to be able to identify children presenting with mental health needs. Appropriate screening processes should be used to recognise/detect mental health and associated risks, such as substance misuse. Typically, these children have experienced family instability and mental health stigma before reaching the emergency department and staff members should be aware of such vulnerabilities. As such, mental health assessments should be explicitly non-judgemental and sensitive to the needs of the child.

It is recognised that urgent and emergency care staff may feel more confident in delivering care for acute medical and traumatic presentations rather than performing mental health assessments. A paediatric liaison health practitioner should support staff with information, training and interagency links. Where this is not available, the urgent and emergency care staff should be able to contact local on-call mental health services, for example the Crisis Resolution and Home Treatment Teams¹¹³.

Upskilling of staff members should ensure that all staff have necessary competency levels in paediatric mental health and the recognition of risky behaviours (i.e. alcohol and drug misuse/sexual activity). Staff should also be able to identify children presenting with medically unexplained symptoms (i.e. when a child presents with physical symptoms solely related to emotional factors, and/or presents with physical symptoms over and above those which would be expected with their medical presentation). Organisations have specifically called for specialised training to enable emergency staff to appropriately assess and care for mentally ill children³⁷.

Caring for children with mental health needs

Effective care should ensure that physical and mental health needs are assessed and managed in parallel to prevent children experiencing a disjointed service and unnecessary delays between assessments. Children presenting with mental health issues for the first time should be given a full physical examination and organic pathology excluded and/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 observations and support that the child/young person requires in order to remain safe in the emergency department^{114,115}. RCEM has developed a toolkit to support the provision of higher quality mental health services in emergency care settings¹¹⁵.

If individualised crisis care management is necessary, the child and their parent / carer should co-author their crisis care plan, which should be circulated with relevant agencies in health, education, social care, judiciary and the third sector. Where electronic records exist, the plan should be clearly located and the child’s attendance for emergency care should be recorded to ensure effective information sharing with other health professionals. Where mental health professionals use separate IT systems to record clinical encounters, it is essential that such records are made available in the emergency department case notes. Local guidelines should be consulted to arrange follow-up CAMHS appointments, although all children presenting with self-harm must be referred for CAMHS review within seven days¹¹⁶.

Urgent and emergency care settings are high-pressure environments catering for varied patient demands, including critically ill patients. They are also usually noisy and busy surroundings. Such settings can be distressing for children with mental health issues, and may exacerbate levels of distress or cause the child to leave the emergency department before their assessment. As far as possible, the built environment should be designed to take account of developmental stage, level of IQ and need for minimising sensory stimulation. All emergency departments must be able to provide a safe, ligature risk-free space for children who are emotionally or behaviourally distressed.

In situations where a child becomes highly distressed and unmanageable with verbal measures or family holding, both pharmacological and physical restraint should be regarded as a last resort; either should only be utilised when in the best interest of the child. Preventative measures such as calming methods and techniques to deescalate behaviour should be considered in the first instance. Restraint should be conducted in accordance with clear guidelines; staff should be appropriately trained, children should be monitored for signs of deterioration, and staff should ensure that communication with the parent/carer about the reasons for restraint/use of sedation are clearly documented.

| Standards | Metrics |
|--|--|
| 39. All CYP presenting to a children’s ED have a developmentally appropriate assessment of their immediate emotional and mental health needs. | <ul style="list-style-type: none"> Guideline available to all staff. |
| 40. A documented risk and capacity assessment should be done for all patients presenting in mental health crisis and this process should commence at triage. | <ul style="list-style-type: none"> Guidance is available to all staff. |
| 41. Adequate and appropriate space is available for children/families in crisis and should include safe space with suitable supervision by emergency staff. | <ul style="list-style-type: none"> Evidence of appropriate space and safe room. |

| Standards | Metrics |
|--|--|
| 42. There is access to mental health records and development of individual crisis plans for each ICYP seen and assessed in mental health crisis in the ED. | <ul style="list-style-type: none"> Evidence of policy for CAMHS liaison and referral, including out of hours. |
| 43. A clear system is in place with service planners to escalate care of patients who require Tier 3(+) in-patient care. | <ul style="list-style-type: none"> Standard operating procedure. |
| 44. Emergency clinicians with responsibility for the care of children receive training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity. | <ul style="list-style-type: none"> Local training programme and evidence of compliance. |
| 45. Telephone availability of paediatric mental health practitioner 24hours a day, 7 days a week, for advice and able to attend for assessment when appropriate. | <ul style="list-style-type: none"> Telephone number that is answered 24/7. |
| 46. Policies are in place for the management of an acutely distressed child or young person incorporating the use of acute tranquilisation and, as a last resort, restraint for those who are acutely disturbed or at risk of harm to themselves or others. | <ul style="list-style-type: none"> Policies available to all staff and included in training programme. |
| 47. When CYP require access to a mental health in-patient bed but there is a delay >4 hrs, they are looked after in a suitable paediatric facility with appropriate in-patient facilities, regular CAMHS review, trained registered mental health nurses and paediatric nursing support. | <ul style="list-style-type: none"> Operational policy. Case note audit. |
| 48. There is a clear pre-identified pathway for patients on a Section 136 order for an identified place of safety to meet their medical and mental health needs. | <ul style="list-style-type: none"> Operational policy. Case note audit. |

Practice Example

Norfolk & Suffolk NHS Foundation Trust – Crisis Service for Children and young people under 18 years

The service provides crisis assessments in emergency departments in local acute hospitals. The team of nurses, social workers, occupational therapists and assistant practitioners provide intensive support to prevent admission into specialist psychiatric hospitals. They also provide:

- Care planning and risk assessments to support ongoing treatment
- Extended hours of availability: evenings, weekends and Bank Holidays
- Consultation and training for professionals
- Intensive support to facilitate discharge and ongoing community-based therapeutic interventions
- Referrals to and liaison with multi-agency partners
- Post crisis intervention referrals to CAMHS / youth services / eating disorder teams / early intervention psychosis teams

The Crisis Service team endeavours to complete a face-to-face assessment within four hours at the emergency department of a local hospital, and will support young people under the age of 18 for a period of up to six weeks.

More details: Dr Jane Evans, Paediatric Emergency Medicine Consultant, Norfolk & Norwich University Hospital jane.evans@nnuh.nhs.uk

RCPCH Resource

RCPCH Doctor's Pocketbook for talking to patients about mental health

<http://www.rcpch.ac.uk/system/files/protected/page/RCPCH-and-Us-pocketbook.pdf>

Chapter 7: Children with complex medical needs

Children and young people can have complex medical needs as a result of their underlying condition. Children may have long-term consequences from extreme prematurity; others have inherited conditions, chronic illness or sustain life changing injury. The spectrum of conditions is not limited to but includes cerebral palsy with significant disability, intractable epilepsy, autism, chromosomal and genetic conditions, chronic lung disease, complex metabolic disease, complicated cardiac disease, oncology or post-transplant.

There are children who are oxygen dependent, have tracheostomies and need regular suction. Some require enteral feeding, either nasogastric or by a gastrostomy or jejunostomy. Poly-pharmacy with unfamiliar medication is not unusual. New technologies such as vagal nerve stimulators, deep brain stimulators or intrathecal baclofen pumps are increasingly frequent. Palliative and end of life care plans may be in place.

Children with complex medical needs can present as an emergency with a complication of their condition or with childhood illness or injury. This presents a number of challenges in assessment and management.

Issues to consider

Emergency care plans

Check if the child has a documented individual emergency care plan. Parents and carers may bring a copy with them. Plans are especially useful for children with rare conditions or who require specific medical management. A visit to urgent or emergency care by a child with complex needs should be used as an opportunity to prompt the preparation of an emergency care plan by the ICYP's lead clinician, if one does not already exist. ED clinicians will need to liaise with lead paediatricians in order to facilitate this. A plan empowers parents and carers to share information about the child's needs quickly in order to receive the most appropriate care. The plan is usually made by the lead clinician and may include details both of emergency management and possibly other special personalised information regarding the patient. If one is not in place, take the opportunity to prompt the lead clinician to prepare one for future reference. The plan needs to be up to date and shared widely, not only with the emergency care settings, but also with the wider professional team such as therapists, specialist nurses, schools, respite care, general practice, community paediatrics and ambulance services¹¹⁷.

Who is with the child?

Children may present with their parents but can be accompanied by a carer or school staff member. Parental responsibility may need to be clarified. Identify the lead clinician who has overall responsibility for care. Be mindful that parents and carers may have had to repeat their complicated history on multiple occasions and over time they will become expert in their child's medical needs. Do not assume that the child will be familiar to clinical environments and acknowledge that this may be distressing. Issues of consent and capacity may be relevant in young people with complex medical needs, especially those over the age of 16 years.

Privacy, dignity and communication

Children with complex medical needs require the same privacy and dignity as any other child. Providing a quiet private environment will minimise distress for children with autism. Communication with children may be a challenge because of physical problems, understanding or behaviour. Always ask the parent or carer if there is anything specific you need to know about how the child communicates and whether the child has a particular way of displaying pain or distress¹¹⁸.

Systematic assessment and knowing what is usual for the child

Emergency assessment needs to be systematic as for any sick child. Consider how this can be achieved safely and adequately; for example, moving a child out of a wheelchair to facilitate an examination needs to be done without causing too much distress. Some children have different anatomy and physiology; understanding their base line is important in evaluating the significance of clinical observations.

Weight, drugs and nutrition

Children 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 should take into account weight and body habitus. Children may require multiple medications, some of which will not be commonly used in emergency departments, and an awareness of potential drug interaction is important alongside consideration of antibiotic resistance as problematic factor. Children with disability or complex needs may have a poor nutritional status, unusual physiology and are at risk of rapid dehydration.

Transition

Emergency attendances by children with complex medical needs must be considered during planning for transition care and must ensure consideration is given over the most appropriate setting for the child's developmental needs. Agreement should be made

between the paediatric and adult department on where to place young people who are transitioning between services, including the most appropriate referral services.

Safeguarding

Children with complex medical needs deserve the same protection and standard of care as any other child. Special attention should be paid to the child's communication support needs. Caring for a child with complex needs can be stressful and should be supported sympathetically, however this does not mean that a lower standard of care is acceptable. Children with limited or no mobility are likely to be osteopenic and may sustain fractures with minimal force and judgement is needed in making safeguarding decisions. Attendances to urgent and emergency care settings must be communicated with the other agencies involved in the child's care, including social workers and the child's care coordinator.

Longer term follow up and care

Children with complex medical needs often have multiple appointments with numerous professionals. Emergency care may occur some distance from home. Ensure the lead clinician is aware of emergency attendances when there are changes or concerns, e.g. increased seizure frequency.

End of life planning for children with life-limiting conditions

Decisions regarding end of life care are complex, require senior decision making and are best planned for in advance. Children towards the end of their lives may have a documented plan or 'wishes document' but can present unexpectedly in extremis when good decisions about starting or stopping resuscitation are needed, ensuring that the child if appropriate and parents and carers are involved in the decision making. Sometimes the child presents in a way which was not predictable and the cause may potentially be reversible¹¹⁹. The lead clinician for the child, together with a senior emergency department professional and the child and/or their parent/carer must work together to care for end of life planning.

| Standards | Metrics |
|---|--|
| 49. Triage systems must consider the additional requirements of prioritising care for children with complex medical needs. | <ul style="list-style-type: none"> Evidence of the use of a triage or early warning system which identifies children with complex needs when allocating priority. |
| 50. When treating a child with complex medical needs, the need to consider early escalation for senior review should be included in all training and induction. | <ul style="list-style-type: none"> Evidence of guideline within training and induction packages. |
| 51. When treating a child with complex medical needs, staff should ask to see the child's emergency care plan. | <ul style="list-style-type: none"> Evidence that updated emergency care plans are easily and readily available in emergency care settings. |
| 52. The needs of children with complex medical needs must be considered within the planning and design of the emergency department. | <ul style="list-style-type: none"> Evidence in design and planning meetings that the needs of children with complex needs have been specifically considered. |
| 53. Where electronic alerts are available these must be used to signpost to relevant information such as emergency care plans or the requirement for an early senior assessment. | <ul style="list-style-type: none"> Evidence that alerts are used to signpost to emergency care plans or special instructions. |
| 54. Information about the child or young person's attendance to an emergency care setting should be shared with the relevant professionals involved with them, including the lead clinician. Links should also be established with local specialist nurse and community children's nursing team to ensure effective follow-up care and support. | <ul style="list-style-type: none"> Evidence of engagement and links with lead clinicians and specialist and community nursing teams. |

Practice Example

Managing children with complex needs in the Emergency Department

D is eight years old. As a result of a complication at delivery he has myoclonic epileptic encephalopathy and has severe learning difficulties and intractable epilepsy. D has an alert on his electronic record that he has an emergency care plan. This is immediately available in a special management plan folder in the Emergency Department. When there are concerns about his seizure frequency there is an established process in place for emergency medicine clinicians to contact his lead clinician or epilepsy specialist nurse by phone or email to advise. The epilepsy specialist nurse will then make contact with the family initially by telephone and is also available for the family to contact directly to assist with admission avoidance.

Acknowledgements

We are grateful for the assistance of the British Association for Community Child Health (BACCH), British Academy of Childhood Disability (BACD) and the RCPCH &Us Network.

Chapter 8: 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 with a focus on large scale trauma has had to evolve. Planning now includes HAZMAT (Hazardous Materials) and CBRN (Chemical Biological Radiological and Nuclear) events, infectious diseases and indeed anything that challenges business continuity, while remaining alert to emerging threats. Not all incidents are sudden, catastrophic “big bang” events with sudden impact multiple casualties; recognition of “rising tide” major incidents, such as pandemic influenza, with lead times of days or weeks to months, as well as “cloud on the horizon” events, such as chemical release or extreme weather events elsewhere needing preparatory action, must inform major incident planning for children and young people.

Under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012, all NHS organisations have a duty to put in place continuity arrangements to identify and manage risks that could disrupt normal service. Guidance is available in each nation that sets out the requirements of planning preparedness, resilience and response to potential threats¹²⁰⁻¹²³.

Children and young people have specific vulnerabilities in emergency and disaster situations, including unique physiological, psychological and developmental needs. It is therefore imperative that emergency planning protocols and training must include a sufficient paediatric focus to enable organisations to respond to a surge of paediatric presentations during any major incident.

“Last year there were loads of terrorist attacks and no one knew what to do and still got hurt...”

RCPCH &Us Voice Bank 2018

Preparation

In England, the Local Health Resilience Partnership (LHRP) facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the health sector on Emergency Planning, Resilience and Response (EPRR). The LHRP develop a strategy and review this annually or sooner (depending on emerging threats and lessons from incidents) to ensure that the local health sector remains prepared for potential major incidents. These will include known and emerging threats and take an all

hazards approach, which will aim to cover unknown or unanticipated threats. In developing the strategy, the diverse health needs of the local communities will be considered.

Children and young people must be specifically considered at a strategic planning level for major incidents, with hospital-wide planning and training in triage, stabilisation and disposition.

Preparation includes:

- Plans for a coordinated health response including suitable command and co-ordination arrangements for the health sector;
- Provision for scaling and mutual aid;
- Provision for joint testing and exercising of plans;
- A framework to ensure that joint plans are current and effective

Some areas of planning required specifically for children can include:

- **Managing directly affected paediatric patients:**
 - Triage – an understanding of age specific physiological variables, as using adult triage parameters will over triage children and overwhelm the system, whilst under triage will lead to increased morbidity and mortality.
 - Paediatric specific skills
 - Equipment availability
 - Familiarity with, and challenges of, using personal protective equipment when managing children
- **Capacity of the emergency department or other services to deal with large numbers of children of varying or similar ages:**
 - numbers and availability of paediatric trained personnel
 - multiple children presenting with special health care needs
 - safeguarding and care of unaccompanied and potentially unidentified children
 - supervised overflow areas for non-admitted children
 - children not directly affected by the event who present with concerns about exposure to infective agents or CBRN agents
- **Networking with other healthcare organisations to provide cohesive services:**
 - networked protocols and training with prehospital agencies
 - availability of specialist units (e.g. paediatric burns or paediatric intensive care beds)
 - provision of psychological support to children, young people, families and staff involved in the incident.
- **Mental Health support**
 - Notifying the child's GP, health visitor or school nurse of the treatment a child has undergone in response to a major incident within 24 hours will enable those services to provide extra support to children in the first two weeks after the event

- Trauma focused cognitive behaviour therapy should be offered to older children with severe symptoms of PTSD that persist longer than a month¹²⁴.
- Debriefing children immediately after such an event can be unhelpful and it is important that emergency care staff do not pathologise the range of emotional behaviours children can exhibit in response to an event.

Incident exercises

Exercises may expose vulnerabilities in an organisation’s structure, initiate processes needed to strengthen both internal and external communication and can help improve management decision making during an incident. They are also used to assess and identify gaps in competencies and further training that is required for staff. Incident exercises should involve the expected number of children proportionate to adults depending on the incident. Coordinated multihospital and multiagency training exercises may help health care facilities prepare for paediatric disaster victims. Incident exercises involving children will be very rewarding, providing important opportunities to enhance preparedness and improve response to major incidents. At the very least children and paediatric medical and nursing staff should be involved in table top exercises and additional measures must be taken when children participate:

- health and safety of children is paramount; protect children from hypothermia and ensure the environment is safe
- safeguarding advice must be sought
- the privacy of children respected if requested
- children should be valued in giving qualitative and quantitative feedback in their own right

| Standards | Metrics |
|--|---|
| 55. The needs of children must be included in the strategic and operational planning and delivery of preparing and responding to major incidents. | <ul style="list-style-type: none"> • Evidence that children are specifically considered at both strategic and operational planning for preparing and responding to major incidents |
| 56. Children, paediatric medical staff and nursing staff must be involved routinely in appropriate incident exercises with the relevant safeguards in place. | <ul style="list-style-type: none"> • Evidence of the involvement of children in appropriate incident exercises with relevant safeguards in place |

Practice Example

Responding to the Ariana Grande concert incident at Manchester Arena

On 22 May 2017, a shrapnel-laden homemade bomb was detonated as people, including many children and young people, were leaving Manchester Arena following a concert by the American singer Ariana Grande. The blast killed the attacker, and 22 others including concert-goers and parents who were in the entrance waiting to pick up their children following the show.

North West Ambulance Service reported that 60 of its ambulances attended the scene, carrying 59 people to local hospitals, and treated a number of walking wounded on site. Approximately 150 people attended Emergency Departments across the city as a result of this incident, including over 40 children. The dead included ten people aged under 20; the youngest victim was an eight-year-old girl and the oldest was a 51-year-old woman. Of those hospitalised and requiring surgery for their injuries, 14 were children under the age of 16, all of whom were treated at Royal Manchester Children's Hospital. Six children required critical care.



The Manchester Bee Mosaic image has been adapted and its copyright notice is listed within the references¹.

Dr Rachel Jenner, Consultant in Paediatric Emergency Medicine and Emergency Medicine at the Royal Manchester Children's Hospital coordinated the Paediatric Emergency Department response after the bomb and contributed to subsequent debriefs and lessons learned.

Dr Jenner reflected that while establishing the identity of the injured is a recognised difficulty in the immediate aftermath of a major incident this was more difficult when the casualties are children, as unlike adults, they tend not to carry bank cards, driving licenses or other means of identity.

She was also aware of the challenge of keeping families together and recommended that this should be specifically considered in casualty dispersal plans to ensure that family members are conveyed to the same receiving hospital wherever possible and kept together. In Manchester, five adults with injuries requiring surgery were admitted to paediatric wards at Royal Manchester Children's Hospital together with their injured children.

Contact detail: Dr Rachel Jenner, Consultant in Paediatric Emergency Medicine and Emergency Medicine at the Royal Manchester Children's Hospital
Rachel.jenner@cmft.nhs.uk.

Chapter 9: Safe transfers

Safe transfers require forethought, preparation, practice and training. Most children requiring inter-hospital transfers are critically ill but some will have complex conditions that have challenged the referring unit's available resources and now require additional tertiary input.

Lower acuity transfers, such as inter-departmental transfers (e.g. from the Emergency Department to the scan room or to a High Dependency area), present similar logistical problems and again require careful planning, utilising the right staff, with the right kit, at the right time; overarching principles that are shared by all successful transfers.

Prehospital (primary) transfers

Paramedics and other pre-hospital specialists are equipped and trained to safely transfer children to the nearest, appropriate medical facility, with the additional option of calling on appropriate help and assistance, when needed.

As soon as is practical, the receiving hospital should be advised of the imminent arrival of any seriously ill or injured child, using the prehospital ATMIST communication tool (A: age, T: time of incident, M: mechanism of injury, I: injury(ies) suspected, S: signs and symptoms, T: treatment administered), to summarise the child's condition.

With the recent advent of regional Major Trauma Networks, Trauma Bypass tools have been developed, putting in place protocols to transfer major trauma patients (children included) directly to a designated Major Trauma Centre (MTC). In many cases, this has seen children bypassing their nearest emergency department, unless they require immediate, local stabilisation of problems such as catastrophic haemorrhage or airway compromise.

Similarly, when centralisation of services has seen local facilities lose on-site paediatric expertise, locally agreed ambulance arrangements/pathways should be developed, to allow seriously ill children to be transferred directly to the nearest local paediatric care provider, unless either i) resuscitation is ongoing, or ii) life or limb is compromised. In these two circumstances, crews should be instructed to transfer to the nearest available medical facility.

The responsibility for initial lifesaving interventions and advanced life support lies with the receiving hospital, which has a duty to provide initial airway, respiratory and circulatory support. (Due to geographical and logistical constraints, regional transport teams cannot be expected to provide these interventions in a timely fashion). Local hospitals must ensure that skilled personnel, trained in advanced paediatric life support, are available at all times, to safely resuscitate and stabilise a critically ill or injured child, whilst retrieval arrangements are being made¹²⁵.

Inter-hospital (secondary) transfers

In many instances, following initial resuscitation and stabilisation in an acute unit, a critically ill or injured child will require transfer to a regional Paediatric Intensive Care Unit (PICU), to receive ongoing critical care. One of the many responsibilities of the recently established regional Paediatric Critical Care (PCC) Operational Delivery Networks (ODN, 2015) is to provide and oversee the running of Paediatric Critical Care Transport Services, to ensure that such children can be transferred safely to PICU.

Clinical advice and guidance for critically ill or injured children should be available from regional PICUs and Major Trauma Centres (MTCs), even when transfer is not indicated or required, via 24-hour telephone helplines. Contact should be made as early as possible, in order to reduce time to transfer and to optimise clinical outcomes.

Whilst the majority of transfers are undertaken by regional Paediatric Critical Care Transport teams, for certain “time-critical” conditions (e.g. severe head injury¹²⁶, intracranial bleeds, thoracic vascular trauma, burns and specified intra-abdominal emergencies), it may be necessary for staff from the initial receiving hospital to transfer the child, to avoid delays and any 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. Such decisions require consultant-to-consultant discussions between the referring hospital and the receiving unit. This can be facilitated via teleconferencing, including all relevant parties where possible, and should typically be led by the PICU consultant on call or trauma team leader, and must include the doctor responsible for the ICYP during the transfer.

Teams performing time-critical transfers must comprise of at least two experienced members of staff, trained to manage the specific risks for potential deterioration encountered during paediatric transfers. Given the potential need for airway intervention, time-critical transfers are commonly performed by suitably trained, experienced anaesthetists. The referring consultant and senior nurse on duty should judge the medical escort’s suitability. Regional training programmes, employing simulated clinical scenarios, can help prepare local teams to safely transfer patients. Use of one of the readily available transfer checklists (*see Practice Example*) can help avoid common pitfalls.

Health organisations must ensure that protocols facilitating time-critical transfers exist, that appropriate drugs and equipment are immediately to hand and have been checked in accordance with local policy, that suitably skilled personnel are readily available (and appropriately indemnified) and that children, 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 that an ‘As soon as possible’ response time is needed, with any communication documented.

Time-critical transfer protocols should include information on how to secure advice from the Transport Service, should detail the composition and expectations of the escort team, should include recommended drug and equipment lists, should provide details on the arrangements for emergency transport and should clarify the escort team's medical indemnity⁵⁰.

The parents/carers of children requiring inter-hospital transfers should be given all possible help and information regarding the transfer, including: the hospital's location, the location of the unit to which their child is being transferred, contact telephone numbers (for both the local hospital and the destination hospital), and practical information such as car parking arrangements etc.

PCC ODN's also have responsibilities to oversee the *local* arrangements for paediatric time-critical transfers within their region.

Inter-departmental / intra-hospital transfers

Standardised arrangements for transfer within a hospital should also be in place (e.g. to or from medical imaging, operating theatre, or other care areas) again employing the principle of the right staff, with the right kit, at the right time. Grab-bags containing appropriate drugs and equipment should be immediately available and checked in accordance with local policy (a list of drugs and equipment for paediatric resuscitation is available from the Resuscitation Council UK⁸⁴).

Such transfers also benefit from planning and preparation and lend themselves to simulated clinical events and multi-disciplinary governance discussions. Therefore, guidelines on the transfer of critically sick or injured children within hospital areas should follow PICS standards⁵⁰ to include information regarding:

- types of patients transferred
- composition and expected competencies of the escort team
- drugs and equipment required
- restraint of children, equipment and staff during transfer
- monitoring during transfer

| Standards | Metrics |
|---|---|
| 57. Each region has a Paediatric Critical Care (PCC) Transport team, provided, managed and governed by its Paediatric Critical Care ODN. | <ul style="list-style-type: none"> • Evidence of a regional PCC Transport Service • Evidence detailing regionally agreed transfer arrangements for critically ill children within the urgent and emergency care network. |
| 58. The regional PICU has a dedicated, 24-hour transfer helpline, for critically ill or injured children, providing clinical support and advice, and co-ordinating paediatric retrievals and transfers. | <ul style="list-style-type: none"> • Evidence of a 24-hour helpline. |
| 59. Local facilities have appropriate staff and equipment readily available, for “time-critical” transfers. | <ul style="list-style-type: none"> • Evidence of safe transfer and escalation policies. • Provision of equipment required for safe transfers, as outlined in PICS guidance. • Evidence of transfer checklists / aide memoires. • Audit of local/regional “time-critical” transfers. |
| 60. ED staff trained in stabilisation and transfer of paediatric patients. | <ul style="list-style-type: none"> • Evidence the ED staff have been trained in stabilisation and transfer of children. |
| 61. Parents and families of children transferred between hospitals are given practical help and information detailing their child’s transfer destination. | <ul style="list-style-type: none"> • Evidence that parent’s receive transfer destination details (address of hospital ward/unit, contact telephone numbers (for both local hospital and destination hospital), car parking details etc). [Since most transfers typically follow an established pathway (e.g. to a regional centre’s PICU, Major Trauma Centre, Burns Unit, Neurosurgical Unit etc.), pre-prepared Parental Information leaflets should be made available]. |

Practice Example

North West London's Critical Care Network's "Transfer Course Aide Memoire"

In 2013, the North West London's Critical Care Network's "Transfer Course Aide Memoire" was a Patient Safety Award Finalist, and is freely available online, offering a concise and helpful pre-transfer check list. The list was updated in 2017 to reflect changes to ambulance priorities and call signs and is available to download via

http://www.londonccn.nhs.uk/_store/documents/aide-memoire-6pp-dl-2017-update.pdf.

Contact detail: critcarenetworknwl@nhs.net

Chapter 10: Death of a child

The sudden and unexpected death of a child or young person is devastating for the family and is challenging for all involved. Parents react individually and many feel overwhelmed. Many different feelings are experienced in an emergency situation and immediately following the death of a child – anger, outrage, utter disbelief, guilt, blame and complete sadness. At such a difficult time families need guidance, information and honest communication. Recognising the impact the death of a child has on professionals is essential. Good communication and coordination between all professionals is vital so that families know what is happening and are involved as far as they are able and encouraged to make informed decisions.

Depending on the nature of the child's condition and death, whether from accident or illness, there are a number of legal requirements that need to be met.

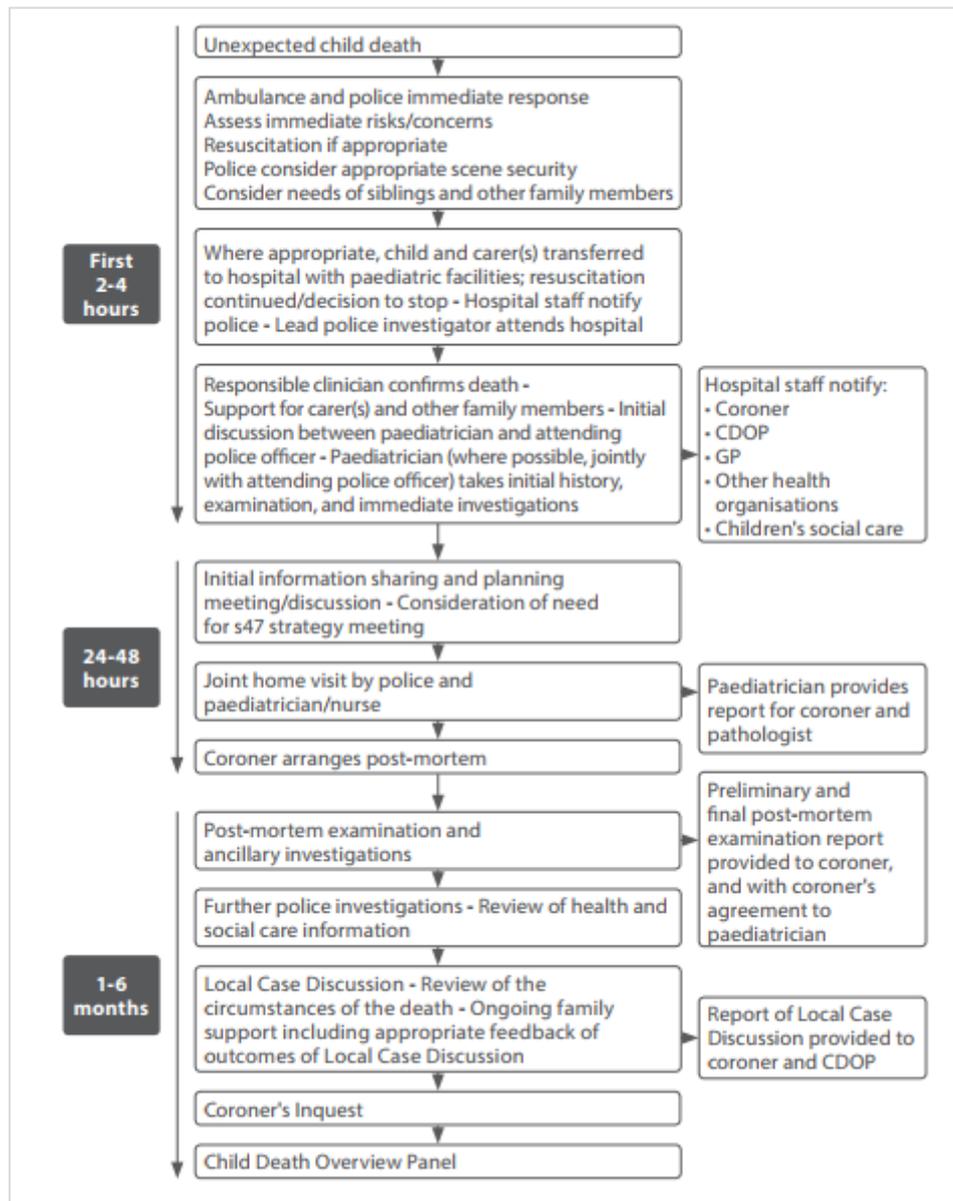
"...an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death." Working Together to Safeguard Children, 2015⁹⁰

This guidance is underpinned by the *Sudden unexpected death in infancy and childhood* report¹²⁷.

Procedures in the case of unexpected deaths

- Local agreed guidelines should, as a minimum, include the following:
- When to stop resuscitation
- Managing the carer/parent and family/other children
- Pathology sampling
- Post-mortem
- Consent
- Cultural/religious beliefs
- How and when to involve the police

Table 2: Process for rapid response to the unexpected death of a child from *Working Together to Safeguarding Children*¹²⁸



In the case of unexpected death there are procedures that must be met including reporting to the coroner, involvement of the designated paediatrician on call for unexpected deaths and the rapid response team (a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child)⁹⁰. Local policies must include an agreed process with the coroner for taking pathology samples at the time of or immediately after the death of a child. Other legal requirements encompass verification of the fact of death, certification and notification of death. There should be clear policies and guidelines in place to support staff in understanding and completing these procedures including clear understanding of local processes on organ donation in children. It is good practice for emergency departments to have a checklist of tasks, which can be

complex and wide-ranging. *Breaking bad news: supporting parents when they are told of their child's diagnosis* is a useful resource for all staff¹²⁹.

If a child has died unexpectedly at home the ambulance and police provides an immediate response where resuscitation will be initiated or continued as appropriate¹²⁷. Where appropriate, the child and their family/carer should be transferred to a hospital with paediatric facilities where resuscitation is continued or a decision to stop is made. If a child is being resuscitated, parents should be allowed to stay with them and are 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. It is important to recognise that it is an individual choice whether to stay in the emergency department or not, and not to assume that all parents would want this.

Supporting families

An experienced member of staff must be identified to support parents, carers and families and explain the situation to ascertain their wishes. Whether the child has died at home, in the community, or within the emergency department, talking to parents and breaking bad news should be managed sensitively, honestly and clearly. There are many resources available that offer guidance and support outlining key steps and principles in communicating with parents.

'Breaking bad news' guidance should be available to support all staff. The way in which bad news is given is an important factor in how it is received, understood and dealt with. It is important that health professionals receive education and training to develop the skills to break bad news effectively in line with the paediatric curriculum¹³⁰. There should be a designated room which is appropriately furnished and equipped for staff to discuss information with families. Families should have access to support services including bereavement support e.g. social workers, chaplains and counsellors.

Recognising the importance of an individual's spiritual, cultural and family beliefs and values should be considered in all communication. It is best to always ask families how we should care for them.

Once a child has died there are a number of decisions that a family can be involved with and it is important for them to be in control as far as possible. They may wish to spend time touching or cuddling their child. 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 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 if applicable.

The possible effects of the death of a child or young person can be far reaching and will impact on wider family and friends. It is important to identify early support for all those affected by a death and guide the family to appropriate resources and support services to help in the days, weeks and years to come. Before leaving the department, parents should be provided with sufficient information to understand all that they need to know in particular the legal and regulatory requirements for example registering the death. This should include information about the involvement of a rapid response for unexpected death with notification to the police.

They should also be given information about how to seek support and advice. An appointment with the hospital bereavement support officer should be made for the next 24-48 hours. Such professionals are trained and skilled in supporting families and identifying any complications experienced through grief and loss.

The parents or carers should also be offered an appointment to see a relevant consultant in order to explain the cause of the unexpected death and offer support at an appropriate interval (often between one and three months after the death)¹³¹. The meeting is usually informed by the results of the post-mortem examination if held. This provides valuable feedback to the emergency care setting on the handling of the situation and their support of the family.

Supporting staff

Support of staff is essential in managing the death of a child and training and education is important in preparing staff for caring for bereaved parents. Opportunities for debrief, personal reflection and supervision should be available for all staff and should be conducted to maximise learning and support any changes to practice that will benefit the department and the care of families.

Further support for staff can be found thorough the Child Bereavement UK¹³², Winston's Wish¹³³ and Together for Short Lives¹³⁴.

National Policy and guidance

Child death review systems inform national multi-agency learning, aid the development of national policy and help identify factors which can reduce preventable deaths¹³⁵.

The current arrangement for reviewing child deaths in England are described within Working Together to Safeguard Children¹³⁶. Local Safeguarding Children Boards are responsible for ensuring that a review of each death of a child is undertaken by a Child Death Overview Panel. In Scotland, a Significant Case Review takes place after a child dies

under the direction of the local Child Protection Committee. And similarly, in Wales and Northern Ireland the National Child Death Review Panel and Safeguarding Board for Northern Ireland advises on the policies and procedures that should be in place (Northern Ireland legislation is awaited). A mechanism required by each committee is that learning from each review is shared in order to improve policies and practice.

A Child Death Review programme is already established in Wales¹³⁷, and England and Scotland are in the process of establishing separate child death review databases. These databases aim to record and monitor the patterns and causes of child deaths in order to provide recommendations and evidence to reduce the risk factors contributing to unexpected child deaths.

| Standards | Metrics |
|--|--|
| 62. All emergency departments caring for children have local agreed policies in place for responding to the unexpected death of a child. | <ul style="list-style-type: none"> • Evidence that policies include the minimum requirement outlined in this chapter. • Evidence that the consultant paediatrician on call is advised as soon as possible about an unexpected child death. |
| 63. Children that have died outside of the hospital setting are taken to a hospital with paediatric facilities*. | <ul style="list-style-type: none"> • Evidence of joint pathways with pre-hospital services. |
| 64. All emergency departments caring for children provide training to staff on how to support carers/parents in response to an unexpected death. | <ul style="list-style-type: none"> • Evidence of training • Evidence that parents are offered an appointment to see the bereavement counsellor swiftly and a relevant consultant at a suitable time interval. |
| 65. Co-operation with the Rapid Response Team and Child Death Overview panel to ensure learning is shared between agencies. | <ul style="list-style-type: none"> • Minutes from meetings documenting representative attendance at Rapid Response Meetings and liaison with Child Death Overview Panel |

*If the family would prefer their infant to remain at the 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 died¹²⁷.

Practice Example



In 2012 Rhian Burke lost her son, George, suddenly in an emergency unit in South Wales. Despite the amazing staff who showed support and empathy at the time of death the family walked out into the dark of the night with nothing, heard from nobody and were left alone to deal with the shock and trauma of losing their son. Five days after George passed away, Rhian's husband Paul, inconsolable and consumed in grief, took his own life. As a result of this tragedy, the charity 2 Wish Upon A Star was established to improve the support offered to families who experience the loss of a child or young person under the age of 25 within the emergency care setting.

An immediate pathway has been developed in hospitals in Wales for the referral of bereaved relatives to access the services provided by 2 Wish Upon a Star for help and support. In the event of a sudden paediatric or young adult death, a memory box will be offered to families so handprints can be taken and locks of hair collected. Consent can then be gained by nursing staff for contact details of bereaved relatives to be shared with 2 Wish Upon a Star.



Nursing staff will clearly document if consent has been gained on the Paediatric Emergency Unit Death Checklist and all details are passed to the 'immediate support worker' on a dedicated number. Within 48 hours of the death of the child or young person, the support worker will then contact the family asking whether they would like a visit. If taken up, the support worker will go out and meet them, continuing weekly (phone correspondence in between if necessary) until it is decided by both parties that this level of support is no longer necessary. Families are then directed to the support groups or one to one counselling with the qualified team provided by 2 Wish Upon a Star. If families, in the first instance, do not require help, the immediate support worker will call back within a week. If the family continue to not require assistance, then he/she will follow up with a letter listing the contact details for support groups provided by 2 Wish Upon a Star for families to keep and use in their own time.

The pilot study at University Hospital of Wales, Cardiff focused on children and young people under 18 years of age. In the twelve months between May 2015 and May 2016, there were 17 paediatric deaths. Each family was offered the memory box with all families agreeing to the memory box in addition to providing consent to their details being passed

onto 2 Wish Upon A star. 16 of those families took up the offer of immediate and on going support with positive feedback.

The memory boxes and immediate support pathway is now available in every emergency unit in Wales. The charity has already received over 300 referrals since May 2015. These are a combination of immediate referrals following recent child and young adult death but also families whose bereavement may be some time ago and feel it is now time to receive formal support.

For more information visit www.2wishuponastar.org

Chapter 11: Information system and data analysis

Information systems

The development of integrated shared health records is a national priority. It is recognised that local issues around information governance are often more risk averse than agreed standards and therefore need to be addressed and managed. Networks of healthcare and social care providers (i.e. Emergency Departments, General Practices, Schools and Social Service Departments) need intuitive information systems that communicate with each other (for example, of good practice - Lambeth and Southwark local healthcare record).

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 indicators.

The system should encompass, or at least be able to link with, all sites in the local network which provide urgent care to children. All current health care of children should be available on the system to facilitate appropriate communication and follow-up. All episodes of care of children should be available including clinics in the community, maternity, fracture and genitourinary, visits to other health professionals and all mental health and ambulance episodes^{3,138}.

"It's important with the access to your health information that they know stuff that links to your injury or if you have an allergy."

RCPCH &Us Voice Bank
2018

Representatives of the emergency care settings in the four countries need to engage with national Information Technology policy and programmes to influence the national agenda and with local service providers to influence the design of their local systems.

Functions of an ideal information system should include:

- demographic data (name, address, date of birth)
- contact telephone numbers (including mobile)
- name of person with parental responsibility
- name of person accompanying child
- mode of transport to hospital
- name of nursery/school/college, if applicable

- name of GP/midwife/health visitor/school nurse, as applicable
- presenting complaint
- previous attendances to the same emergency department
- the location, if the presentation is for an injury, for injury prevention surveillance
- 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
- a real-time service delivery function, such as patient tracking within the emergency care setting, electronic ordering of tests, prescribing, etc.
- real-time clinical support, including alert categories, linkages to individual care plans, and a method of identifying previous attendances and frequent attendees
- a reporting system with good clinical coding,

Other sources of information are easily available to support the clinicians such as the Toxbase website¹³⁹, standards for emergency care discharge summaries¹⁴⁰, local clinical or operational guidelines, decision support software, online medical information services, and search engines. These are best linked to clinicians' personal CPD data.

Clinical Coding and the Emergency Care Data Set

In England it will start to become a requirement from October 2017 for all Emergency Departments to provide reports in keeping with the Emergency Care Data Set¹⁴¹ (ECDS). This contains an agreed set of data which is SNOMED Clinical Terms compliant. SNOMED-CT is an internationally agreed system of clinical coding which has been adopted by NHS England.

The Emergency Care Data Set system is a minimum standard, though trusts can choose to collect more information relevant to understanding performance, e.g. presenting details and complaints, investigations, treatments and discharge diagnosis. It also includes information to facilitate audit and clinical governance within the emergency care setting (e.g. national recommendations, and injury surveillance) and information about service provision (e.g. timings of the patient journey and staff performance statistics). Ongoing development will eventually include quality outcome measures (national such as CEM analgesia use in trauma as well as locally defined clinical outcome measures that can monitor and drive local service improvements). Emergency Care Data Set standards developed by the Professional Record Standards Body should be followed to ensure discharge information is transferred quickly to the child's GP for ongoing care and treatment.

Injury surveillance

Injuries are the most common cause of death and preventable morbidity in children and young people aged 1 year and over. Primary injury prevention is one of the least well researched, and underdeveloped elements of children's services. Knowledge of the epidemiology of injury is critical to prevention. Information about accidents in the local area should be available from the emergency department database, and can be used to inform local government policy, the media, and the police, within the limits of patient confidentiality¹⁴².

The Trauma Audit and Research Network (TARN) is the recommended method of assessing the quality of trauma care, and outcomes following severe injury¹⁴³. The CEM national audit of use and timeliness of analgesia in children with injuries is another important quality audit measure⁷⁸.

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. In Scotland¹⁴⁴, Wales¹⁴⁵ and Northern Ireland^{146,147}, development of clinical quality indicators for urgent and emergency care are at an early stage. The Department of Health clinical quality indicators for emergency departments in England¹⁴⁸ were introduced in April 2011 and replace the less sophisticated four hour target for arrival and discharge.

'Good' care will invariably satisfy six criteria¹⁴⁹:

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

It is likely that unplanned re-attendance rates for children, especially for children less than 5 years, will be appropriately higher than adults due to the evolving nature of childhood illnesses. Adult and paediatric rates can be usefully monitored separately and ideally the re-attendance rates for under 5s 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.

| Standards | Metrics |
|--|---|
| <p>66. All emergency care practitioners treating children in the urgent and emergency care network have information systems that provide basic demographic and episode related information.</p> | <ul style="list-style-type: none"> • Evidence of access to children’s basic demographic and episode related information. • Evidence of integrated health information systems, so that data on all local health service contacts are available with the emergency care setting. |
| <p>67. All health organisations providing emergency care to children must collaborate with national information centres (i.e. NHS Digital) to involve and inform of the needs of patients, clinicians, managers and service planners/commissioners in developing emergency care information systems.</p> | <ul style="list-style-type: none"> • Evidence of collaborative working with national information centres when developing emergency care information systems. |
| <p>68. All emergency departments treating children collect performance data that is used to improve services locally and to benchmark performance nationally.</p> | <ul style="list-style-type: none"> • Evidence that injury surveillance data is collected and accessible. • Subscription to the Trauma Audit and Research Network (TARN) for hospitals in England and Wales. • Evidence of data collected using nationally defined indicator sets to enable service planning and quality improvement. |
| <p>69. Emergency departments treating children adhere to Emergency Care Discharge Summary Standard.</p> | <ul style="list-style-type: none"> • Evidence that discharge summaries are compliant with PRSB standards¹⁴⁰. |

Chapter 12: Research for paediatric emergency care

Research in paediatric emergency medicine

Emergency medicine and paediatrics have both been identified as important areas of development by the National Institute for Health Research (NIHR). The resulting opportunity to build on existing successes in PEM research may bring increased resources to further drive and support these activities. Engagement with and support from existing infrastructures will enable all involved in paediatric urgent and emergency care to participate in and/or organise research studies, regardless of their previous academic experience. This should be a core activity due to the limited evidence which exists for many aspects of paediatric emergency medicine and current delays in implementing research findings into practice, both of which lead to substantial variation. Focus should be on both primary and secondary research, to generate new information and synthesise existing evidence, with the ultimate goal of knowledge translation and tangible improvements in clinical care.

Paediatric Emergency Research in the UK and Ireland (PERUKI) is the PEM clinical studies group network which brings together clinicians and academics to collaboratively develop and deliver high quality multicentre research. They have highlighted how emergency departments provide an invaluable environment in which to perform research, as presentations encompass a wide range of childhood illness and injury; however, they also note a number of challenges which persist including, but not limited to, funding limitations, a lack of quality data, clinical and performance pressures, and restricted consent⁶⁸. To date they have performed several studies which have prioritised key clinical areas for PEM research, and demonstrated variation in practice for common conditions, the first steps to future study and standardisation. They are also delivering NIHR funded multi-centre research on a number of conditions including sepsis, convulsive status epilepticus, and childhood pneumonia. These successes have been driven by the grassroots involvement of PEM clinicians who, often despite limited resources and limited 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 key skills and further this vision.

PERUKI's aim is to improve emergency care for children 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 translation of findings;
- Promoting sharing of expertise within the UK and Ireland, and the rest of the world;
- Mentoring junior PEM researchers to create sustainability.

The existence of PERUKI has also facilitated involvement with research on a global scale through membership of Paediatric Emergency Research Networks (PERN), and its member organisations. However close relationships with existing networks and organisations closer to home are also key to PEM research. Just as in clinical care, PEM research often crosses boundaries into other specialties, and successful delivery requires multi-professional collaboration and team working. Working with the NIHR Children Specialty’s Clinical Studies Groups, and other research networks such as General and Adolescent 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 structure may help unlock the full potential of PEM teams where there is enthusiasm to be involved.

At a College level there is guidance on several aspects relevant to PEM research. In 2016, the RCPCH produced the Infants’, Children’s and Young People’s Child Health Research Charter¹⁵⁰. This Charter supports children, young people, 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 research¹⁵¹.

| Standards | Metrics |
|--|---|
| <p>70. All emergency departments treating children have a nominated lead for paediatric emergency research with PERUKI membership¹⁵².</p> | <ul style="list-style-type: none"> • Named person. |

Membership of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings

| | |
|---------------------|--|
| Dr John Criddle | Chair |
| Ms Emily Arkell | RCPCH Head of Policy |
| Ms Melissa Ashe | RCPCH Policy Lead |
| Dr Jason Barling | RCPCH Member |
| Dr Stewart Cleeve | British Association of Paediatric Surgeons |
| Dr Francesca Cleugh | RCPCH Member |
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| Dr Virginia Davies | Royal College of Psychiatrists |
| Dr Carol Ewing | RCPCH Vice President Health Policy |
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| Dr Scott Hendry | RCPCH Regional Representative Scotland |
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| Dr Helen Stewart | RCPCH Trainee Representative |
| Dr Felicity Taylor | RCPCH Member |
| Dr Zoe Roberts | RCPCH Regional Representative Wales |

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