# STANDARDS FOR CHILDREN'S SURGERY

## Children's Surgical Forum


2013

# Endorsed by

**The Association of Paediatric Anaesthetists of Great Britain and Ireland**
**The Association of Surgeons of Great Britain and Ireland**
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**The Royal College of Surgeons of England**
**The Society for Cardiothoracic Surgery in Great Britain and Ireland**

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# Contents

# 1 Foreword

Providing children with the best possible patient experience and outcomes from health care is vital. In support of this, care should be delivered locally, where safe, and centrally, where necessary. Clinical networks have been a success in the NHS and have an important part to play. They provide links between commissioners, local hospitals and specialist centres to ensure children are treated safely in an appropriate environment that is as close to home as possible.

The NHS Future Forum supported clinical networks in the reformed NHS and work has been going on over recent months to ensure that they are developed and embedded. Extending the areas to be covered by clinical networks to include conditions and patient groups, which had not previously had formal networks, was part of this work. It was clear that clinical networks can have a positive impact on the delivery of clinical care to improve outcomes for patients, and have great potential to help facilitate yet further improvement.

The landscape of the NHS is changing and will continue to change over the coming years. The decision by the NHS Commissioning Board (NHSCB) to include maternity and children's services in the initial group of strategic clinical networks supports the view that, based on the nature of work, a network approach will support both commissioners and providers in the planning and delivery of care. These strategic clinical networks will link closely to the local provider networks described within these standards.

Commissioners are central to shaping NHS services and, when making decisions regarding services needed in their area, they will have improving patient outcomes at the forefront of their minds. Support in this will be available from a variety of sources, including guidance published by medical royal colleges and specialty associations.

Ensuring an excellent standard of care will help improve outcomes. I hope that the standards defined in this document will be considered when the work plans for clinical networks are being developed to ensure that care is delivered to improve outcomes and patient experience. I commend this report to you as a means of achieving this.

**Dr Kathy McLean**
Clinical Transitions Director, NHS Commissioning Board

# 2 Executive summary

The following summary should be read in conjunction with the full standards.

This document provides standards for the provision of children's surgery. The overarching principle of these standards is to ensure children can receive surgery in a safe, appropriate environment, which is as close to their home as possible. This document advocates that local provider networks give on-going support to surgeons, anaesthetists and the whole multidisciplinary team involved in delivering surgical care to children in local hospitals. Such support will enable this vital service to be delivered locally, while establishing agreed policies and processes for transferring patients and their families when their needs cannot be met at the local level.[1]

## Networks

The majority of children's surgical services should be designed and delivered as part of an appropriately resourced network that works closely with clinicians from all disciplines and with commissioners, for the benefit of children and their carers. The network must have a clear governance infrastructure and refer to national standards and outcomes of care.

There must be an identified clinical network lead. There must be regular (at least annual) network review of patient outcomes and experience. The network is supported by contractual agreements that specify service requirements and outcomes and has appropriate administrative and financial resources. The network will therefore need to work closely with commissioners regarding objectives and work plans.

## Governance and leadership

Within hospitals providing surgical services for children there must be a commitment from the executive team and senior staff to the provision of a high quality children's surgical service, with a multidisciplinary children's surgery committee reporting to the board.

There must be a defined governance structure to assure the quality of overall care and encourage and monitor improvements in the surgical and anaesthetic services. This will be facilitated by regular and systematic capture of patient and carer-reported outcomes, including those admitted for unscheduled care.

The service should submit data on request to agreed regional networks and national audits.

## Education and training

All clinicians caring for children and young people in a surgical or anaesthetic context should undertake an appropriate level of paediatric clinical activity that is sufficient to maintain minimum competencies (as defined by their respective medical royal colleges) and consistent with their job plans. This requires both time and financial support and should be a feature of regular annual review of practice at appraisal. Mechanisms

across clinical networks should be in place to ensure staff competency and identify training needs. Networks should support and develop staff and, when possible, provide continuing professional development (CPD).

## Patients and family

There must be a system of communicating the name of the responsible consultant(s) to parents and families and to enable access to a dedicated member of staff throughout the admission. Children and families should be represented in the design of surgical clinical networked services. They should also be involved in the decision to operate and the consent process. The processes and environment in which surgical and anaesthetic care are delivered should ensure that distress is minimised and parental access is encouraged, eg to anaesthetic and recovery areas. Arrangements must be in place to ensure that appropriate and understandable information is provided to parents, including after they have left the hospital and subsequent sources of support. There must be frequent communication with the family throughout the hospital stay, at all times ensuring patient privacy and confidentiality. Families should be involved in wider decisions on service organisation.

## Delivery and environment of care

Children should be treated in safe, suitably staffed and equipped, child and family–friendly environments. Surgery must be performed by clinicians with the appropriate competencies. This infers completion of a dedicated training programme in paediatric surgery to Certificate of Completion of Training (CCT) level or attainment of a CCT in another relevant surgical specialty, such as general surgery. The range of competencies attained by an individual is specified in the respective curriculum.

### Elective care

Elective surgery for children should, whenever possible, be scheduled on dedicated children's theatre lists. Where this is not possible, cases are scheduled considering the needs of children and carers.

A named consultant[a] paediatrician must be available for liaison and immediate cover, for example in cases of children requiring on–going care following resuscitation, and to advise on safeguarding issues. While such situations are rare, the level of cover should ensure attendance within 20–30 minutes.

### Wards

The on–going care of inpatients/postoperative patients is managed by consultant surgeons, with support from consultant paediatricians where necessary, on children's wards staffed by registered children's nurses and senior surgical trainees (or surgical trust doctors with equivalent competencies).

### Outpatient departments

Whenever possible, children should, be seen in designated children's clinics. When this is not possible, cases should be scheduled with consideration for the needs of children and carers.

### Emergency care

For emergency surgical conditions not requiring immediate intervention, children should not normally wait longer than 12 hours from decision to operate to undergoing surgery, and should be scheduled with consideration for the needs of children and carers. Surgeons and anaesthetists taking part in an emergency rota that includes children must have appropriate training and competence to handle their immediate surgical and anaesthetic care.

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a. Or equivalent SAS grade. See *Facing the Future: Standards for Paediatric Services*.[20]

There should be a policy to support clinicians if unexpected circumstances require that they must act beyond their practised competences and are undertaking life–saving interventions in children who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available. There must be immediate access to senior paediatric support when required.

Hospitals admitting emergencies must have the required resources and equipment to stabilise and resuscitate infants and children at all times. Emergency children's surgical practice is audited at least annually using routinely collected data, and clinical governance data such as sudden untoward incidents.

**Day surgery**

Day surgery should be provided for children whenever practical, with a named consultant surgeon responsible for care. As with inpatient surgery, a named consultant[b] paediatrician should be available for liaison and immediate advice and cover, and outcomes should be audited and reviewed.

When day surgery is undertaken in a centre without inpatient paediatrics, a neighbouring children's service must take formal responsibility for the children being managed in the unit, and there should be a clear plan for transfer should this be necessary. This may require a (formal) service level agreement to be in place.

b. Or equivalent SAS grade. See *Facing the Future: Standards for Paediatric Services.*[20]

# 3 Background

It is more than five years since the Children's Surgical Forum (CSF) published *Surgery for Children: Delivering a First Class Service*,[2] providing generic and specialty–specific standards for children's surgery. During those years, the landscape of the NHS has altered dramatically due to changes in funding and reform to the way in which services are planned, commissioned and configured. Now more than ever, the configuration of services in England is largely driven by commissioners, meaning that it is increasingly commissioners (including clinical commissioners) who are responsible for shaping the services provided by the NHS.

In order to support commissioners and service planners to achieve excellent outcomes, both clinically and in terms of patient experience and expectation, the profession must provide a clear understanding of what a service should look like. The Safe and Sustainable surgery programmes[3] and Equity and Excellence Specialised Services Transition[4] in England have considered how highly specialised areas of children's surgery should be developed and have ensured that these services are centrally defined and managed. Furthermore, the Children and Young People's Health Outcomes Forum have published a report and recommendations to identify the outcomes that matter most for children and young people.[5] The maternity and children's services strategic clinical networks are intended to encourage an integrated, whole–system approach to care, and assist commissioners in reducing variation in services.[6]

However, there is still work to be done relating to children's surgical services. Areas in which services could be improved, particularly through the more widespread implementation of local provider networks, have been identified.[7–11] Such networks will be able to link to the strategic clinical network for support and to ensure an integrated approach. Both the Royal College of Paediatrics and Child Health (RCPCH)[12] and the CSF[1] have highlighted previously the benefits of such networks to deliver and quality assure children's surgical services. Successful networks ensure that children are safely treated as close to home as possible and have access to the appropriate level of care, with high quality resources delivered by the correct staff with appropriate skills. Networks underpin the local delivery of safe services, provide opportunities for training, CPD and refresher training, and support to clinicians if unexpected circumstances require that they act beyond their practised competences.

# 4 Purpose of this document

This document provides information and standards for children's surgical service provision. It is aimed at all those involved in commissioning, planning and delivering services, including medical and nursing staff and managers at both trust and network levels. This document intends to help them ensure the services they design meet expected levels of quality and attain excellent outcomes in relation to governance, organisation of care, patient experience, training, and service delivery.

It is acknowledged that there are a number of existing networks for children's surgery and this document seeks to build on their successes to work towards further improved services. Many of these networks have developed, and adhere to, comprehensive standards of care; the aim of this document is not to replace these. It applies primarily to services in England but may also be of interest to Wales, Northern Ireland and Scotland, where separate systems exist to manage networks. It is hoped that this document will provide a practical and user–friendly guide that can be used as an audit tool to assist planners, commissioners and providers of children's surgical services in all sectors to assess their performance.

The CSF has compiled this document in collaboration with colleagues across specialties and professions involved in the design and delivery of children's surgical services.

# 5 Overarching principle

The overarching principle for children's surgery is that children are treated safely, as close to home as possible, in an environment that is suitable to their needs, with their parents' involvement in decisions, and with the optimal quality of care being delivered. In addition, all those involved in children's surgical services are suitably trained and supported.

# 6 Configuration of services

Children are treated as close to home as possible by staff with the right skills at centres with the right facilities. The care of unusual or complex conditions is concentrated in specialised settings. The majority of children's surgical services are provided via local provider networks. These link to strategic clinical networks and may be supported by these. The following standards are aimed primarily at local provider networks to ensure that all providers of children's surgery should meet consistent standards.

| | **Standard** | **Measurement criteria** |
|---|---|---|
| 6.1 | There is an identified network lead/director. | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. |
| 6.2 | The network is supported by contractual agreements that specify service requirements and outcomes and is appropriately resourced on an administrative and financial basis. | ▸ Copies of contracts.<br>▸ Appropriate audit and review. |
| 6.3 | Clinician succession is planned to ensure the future sustainability and integrity of the network. | ▸ Workforce mapped on an annual basis. |
| 6.4 | There is multidirectional flow of services within the network. | ▸ Description of services. |
| 6.5 | Agreed guidelines and protocols for managing the service are in place covering the full patient pathway.<br><br>**Best practice**<br>There is a forum for sharing best practice and development of the service including all contributors.<br><br>Methods of communicating with all those delivering children's surgical services within the unit/network are established. | ▸ Protocols and guidelines in place.<br>▸ Regular assessment of performance in place.<br>▸ Evidence of working to National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), or other national guidelines where available.[c] |
| 6.6 | There is regular (at least annual) network review of patient outcomes and experience. | ▸ Evidence of review.<br>▸ Measures to improve service delivery are in place. |
| 6.7 | Processes are in place to identify and monitor network risks and critical incidents. | ▸ Evidence of written processes.<br>▸ Examples of responses to effect change. |
| 6.8 | Defined arrangements and standards for the transfer of children are in place and adhered to and regularly audited. | ▸ Regular (not less than annual) audit by networks with involvement of relevant surgical teams. |

c. For example, NICE quality standards: http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

| | Standard | Measurement criteria |
|---|---|---|
| 6.9 | Children's surgical services delivered via a network have arrangements in place for image transfer and telemedicine and agreed protocols for ambulance bypass/transfer.<br><br>**Best practice**<br>Planning ensures adequate beds are available across the network to reduce delays for children being transferred. | ▸ Arrangements agreed.<br>▸ Written policy on transfer/ bypass, audited regularly. |

# 7 Governance and leadership

The service is supported at trust board(s) level and operates within a defined clinical governance framework. The service is recognised and prioritised appropriately in terms of workforce, equipment, facilities and so on. The network has suitable recognised leaders who are accountable for ensuring the network operates according to agreed protocols and agreed standards of care and best practice.

| | Standard | Measurement criteria |
|---|---|---|
| 7.1 | There is a designated children's lead at trust board level. | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. |
| 7.2 | There is commitment from the executive team and senior staff to the provision of a high quality children's surgical service. | ▸ Demonstrated in the organisation's published plans, reports and the presence of a management structure to support the service. |
| 7.3 | There is a defined governance structure to assure the quality of the service and allow for continuous improvement. | ▸ Governance structure and regular discussion at trust board level. |
| 7.4 | The children's surgical service has an identified children's nurse lead.<br><br>**Best practice**<br>Throughout the care pathway, children are looked after by registered children's nurses.[13,14] | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. |
| 7.5 | There is a designated lead responsible for managing quality assurance data regarding the performance of the network. All networks collect data to capture information on relevant annual surgical and anaesthetic activity. | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. |
| 7.6 | Leads have provision within their job plan to champion and develop children's surgical service provision within the organisation. | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. |
| 7.7 | All who come into contact with children and parents have complied with the NHS employment checks, including criminal records bureau (CRB) checks.<br><br>**Best practice**<br>Where clinicians work in multiple centres, agreements are in place to provide assurance to all parties that NHS employment checks have been carried out by the main employer. | ▸ Evidence of HR checks.<br><br>▸ Use of the Certificate of Fitness for Honorary Practice.[d] |

d. Due to be published in 2013 by NHS Employers.

| | Standard | Measurement criteria |
|---|---|---|
| 7.8 | Arrangements are in place to safeguard and promote the welfare of children and young people, and to cooperate with other agencies to protect individual children and young people from harm. | ▸ Copies of policy/arrangements. |
| | Staff are provided with sufficient time and opportunity to ensure they are able to meet this requirement. | ▸ Example job plans/arrangements demonstrating opportunities provided. |
| 7.9 | All staff who come into contact with children and young people are trained in safeguarding to the appropriate level as defined in the intercollegiate framework *Safeguarding Children and Young people: roles and competences for health care staff*.[15] | ▸ Copies of valid Mandatory and Statutory Training (MAST) certificates. |
| 7.10 | The service submits data to prescribed national audits. | ▸ Participation monitored via quality accounts.<br>▸ Outcomes monitored through governance systems.<br>▸ If appropriate, outcomes are monitored via the commissioning board. |
| 7.11 | There is a programme of audit across all elements of the service. | ▸ Evidence of audit.<br>▸ Outcomes monitored through governance systems. |
| 7.12 | There is a regular (at least annual), multidisciplinary review of patient outcomes involving all relevant specialties.<br><br>Regular M&M/MDT reviews of individual cases take place to identify areas of good practice and areas for improvement.<br><br>Processes for identifying critical incidents and monitoring action plans are in place, for example, engagement with clinical quality review processes of commissioners.<br><br>**Best practice**<br>There is regular and systematic capture of patient and carer reported outcomes, including those admitted for unscheduled care.<br><br>Risk and clinical governance groups review the outcomes of children's surgery.<br><br>SHMI data are reviewed within organisations for unscheduled surgical care at specialty level | ▸ Notes of and actions from morbidity and mortality (M&M)/multidisciplinary team (MDT) meetings.<br>▸ Data is benchmarked against national outcomes where available.[e]<br>▸ Board scrutiny of serious untoward incidents, summary hospital-level mortality indicator (SHMI) data and other outcome-based information.<br><br>▸ Trust engages with quality review processes of commissioning organisations. |

e. For example, *The NHS Outcomes Framework 2012/13*[16]

| | Standard | Measurement criteria |
|---|---|---|
| 7.13 | There is a policy in place and an identified lead for the transitional care of young people moving to adult services, including children and young people with special needs.[17] | ▸ Policy in place.<br>▸ Role identified in job plan and reviewed at appraisal. |
| 7.14 | Structured arrangements are in place for the handover of children at each change of responsible consultant/medical team. Adequate time for handover is built into job plans.<br><br>**Best practice**<br>Electronic transfer of care documents to assist with verbal handover arrangements. | ▸ Handover processes and documentation. |
| 7.15 | The WHO *Surgical Safety Checklist*[18] (or a local variant thereof) is used for all appropriate procedures. | ▸ Local arrangements and audit. |
| 7.16 | There is a written policy regarding the age range of children anaesthetised and operated upon within the hospital (and for the out-of-hours period if the level of paediatric anaesthetic competences is different). | ▸ Written policy with annual review.<br>▸ Effectiveness of policy is evaluated with audit of outcomes, including transfers and untoward incidents. |
| 7.17 | Pain management policies are in place and followed. A pre and postoperative pain assessment takes place for every child. All nurses and support workers delivering care to children and young people are competent in this. The service is supervised by a paediatric anaesthetist. | ▸ Policy document.<br>▸ Regular audit. |

# 8 Education and training

The training and development of all staff involved in the service is supported. There is a network-wide approach to identifying and addressing training and education needs.

| | Standard | Measurement criteria |
|---|---|---|
| 8.1 | Mechanisms are in place to assess staff competency and identify training needs. | ▸ Records of annual appraisal and personal development plans. |
| 8.2 | Provision is made in job plans for all staff to participate in training and CPD activities. Networks support, develop and provide CPD. Medical royal colleges set standards for CPD in their respective specialties and provide guidance and tools to support doctors in planning and managing their CPD activities. | ▸ Example job plans with supporting professional activity (SPA) time allocated.<br>▸ Description of CPD activities provided. |
| 8.3 | Staff are provided with opportunities to fulfil training and CPD needs, for example through the use of training courses, secondments or proleptic appointments. | ▸ Example arrangements for secondments etc. |
| 8.4 | Consultants work within the limits of their professional competence and, where there are unexpected circumstances requiring that they act beyond their practised competences, support is available from colleagues within the service / network.[19] | ▸ Description of support. |
| 8.5 | Training in children's surgery is organised according to the requirements of the relevant specialty curriculum. | ▸ Recorded in annual review of competence progression (ARCP). |
| 8.6 | Trainees' supervision is appropriate to their level of competence. | ▸ Recorded in ARCP. |
| 8.7 | All surgeons and anaesthetists operating on, and anaesthetising, children regularly undertake paediatric life support training. | ▸ Recorded in appraisal. |
| 8.8 | Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer maintain their skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job. | ▸ Recorded in appraisal.<br>▸ Example job plans. |

# 9 Patients and families

Children and their families receive appropriate information about their treatment and are involved as appropriate in decisions about their care. Facilities are provided to ensure children and their families are as comfortable as possible throughout their care.

| | Standard | Measurement criteria |
|---|---|---|
| 9.1 | Children and families are able to access, at all times, a dedicated member of staff with whom they can discuss (or arrange discussion with the relevant clinician) treatment options, diagnostic findings, expected recovery timescales, complications, etc. | ▸ Role description/rota for this post.<br>▸ Patient-reported experience measures (PREMs) are monitored. |
| | **Best practice**<br>Patient experience standards for this role are in place. | ▸ Patient experience standards in place and audited. |
| 9.2 | There is a system of communicating the name of the responsible consultant to patients and families, occurring on admission and at every change of consultant responsibility. | ▸ Monitored on a ward-by-ward basis. |
| 9.3 | Information is provided to patients and supporters at each stage of the care pathway. Communication with patients and supporters is consultant-led. | ▸ Presence of written information where applicable.<br>▸ PREMs are monitored. |
| 9.4 | Printed patient information leaflets on common children's surgical conditions and anaesthesia are available.<br><br>**Best practice**<br>Patient information is also available electronically. | ▸ Presence of information literature. |
| 9.5 | The service has arrangements to provide support services such as translation, play therapy and other necessary therapies, social care, interfaith, advocacy advice and support, health visitors and liaison nurses. | ▸ Description of services offered. |

| | Standard | Measurement criteria |
|---|---|---|
| 9.6 | The decision to operate includes the provision of information, informed consent and confidentiality.<br><br>Arrangements are in place to ensure that guidance on consent for treatment and sharing information with supporters is followed. | ▸ Examples of information provided to parents' carers.<br><br>▸ Written policy in place. |
| 9.7 | Procedures minimise anxiety for the child (eg shortest fasting times, allowing children to wear their clothes to theatre, imaginative modes of transport to and from theatre, taking into account safety and good communication among staff to minimise waiting times). | ▸ Description of facilities. |
| 9.8 | Where appropriate, the child contributes to decisions regarding their care according to their understanding. Patients and carers are kept updated of changes as they occur. | ▸ PREMs are monitored. |
| 9.9 | The anaesthetic room is child friendly and parents are supported in comforting their children during induction. | ▸ Description of facilities. |
| 9.10 | In the recovery area, there is a physical separation between children and adult patients. Parents/carers are able to be present with their child when they wake up. | ▸ Description of facilities. |
| 9.11 | As soon as possible post-surgery a member of the medical/nursing team updates the child's family of the outcome of surgery. | ▸ Feedback from children and family. |
| 9.12 | Information about patients and their conditions is imparted in a sensitive manner and communicated in such a way as to preserve privacy, dignity and confidentiality. | ▸ Provision of private facilities for discussion.<br>▸ Feedback from patients/supporters. |
| 9.13 | Patients and their families are given clear information on discharge from the service and are able to make contact with a healthcare professional for advice and support following discharge.<br><br>Primary care colleagues receive timely and accurate discharge information in order to support the patient in primary care.<br><br>**Best practice**<br>The service offers a telephone follow-up service for patients and has defined links with general practice. | ▸ Standard written information is available.<br>▸ Evidence of telephone advice offered.<br>▸ Feedback from patients/supporters.<br>▸ Description of telephone follow-up service and GP links. |

| | Standard | Measurement criteria |
|---|---|---|
| 9.14 | The service has mechanisms to receive feedback from patients and supporters.<br><br>**Best practice**<br>The service has a rolling programme of capturing and auditing a sample of patients' experiences of the service and acts upon the results. | ▸ Patient experience measures are in place.<br>▸ Feedback audited regularly. |
| 9.15 | Mechanisms are in place to involve patients and their family in decisions about the organisation of the service. This should include patient/ family groups who are part of a network of regional or sub–regional services. | ▸ Evidence of patient involvement in decisions about service development. |

# 10 Delivery and environment of care

Children are treated by staff of the appropriate level and skill in an environment providing suitable facilities. Surgery must be performed by clinicians with the appropriate competencies. This infers completion of a dedicated training programme in paediatric surgery to CCT level or attainment of a CCT in another relevant surgical specialty such as general surgery. The range of competencies attained by an individual are specified in the respective curriculum. Children are segregated from adult patients. Care is delivered in a child and family–friendly environment.

## Elective care

| | Standard | Measurement criteria |
|---|---|---|
| 10.1 | As far as possible, adults and children are segregated in all service areas. Where this is not possible arrangements are made that recognise the needs of children and their carers. | ▸ Description of facilities. |
| 10.2 | Elective surgery for children is scheduled on dedicated children's theatre lists. Where this is not possible, cases are scheduled with consideration for the needs of children and carers. | ▸ Example lists.<br>▸ Evidence of measures in place working towards separate lists where volume is sufficient.<br>▸ PREMs are monitored. |
| 10.3 | A named consultant[f] paediatrician is available for liaison and immediate advice and cover.<br><br>**Best practice**<br>The patient has 24/7 access to a consultant paediatrician.[20] | ▸ Description of services and rotas. |
| 10.4 | In exceptional circumstances where a child requires care from specialist surgical nurses or in specialist facilities within an adult setting, there is liaison with a named registered children's nurse. | ▸ Record of named children's nurse. |
| 10.5 | When children are admitted to departments other than the children's unit (eg, emergency department (ED) or x–ray), there is a process of liaison with a named nurse in the children's unit to ensure appropriate advice is available (eg, on consent issues and pain management). The advice of a play specialist is also sought. | ▸ Record of named children's nurse and play specialist. |

f. Or equivalent SAS grade. See *Facing the Future: Standards for Paediatric Services*.[20]

| | Standard | Measurement criteria |
|---|---|---|
| 10.6 | Sufficient staff are trained, and maintain competencies, in life support on any one shift. In clinical areas (eg ED, inpatient medical and surgical wards, recovery areas and day-case facilities) this is to advanced levels eg, Advanced Paediatric Life Support (APLS), European Paediatric Life Support (EPLS) or equivalent. | ▸ Example rotas.<br>▸ Evidence of training. |

## Wards

| | Standard | Measurement criteria |
|---|---|---|
| 10.7 | Children are not admitted to adult wards. | ▸ Regular audit. |
| 10.8 | The on-going care of inpatients/postoperative patients is managed by consultant surgeons, with support from consultant paediatricians where necessary, on children's wards staffed by registered children's nurses and senior surgical trainees (or surgical trust doctors with equivalent competencies). | ▸ Description of service.<br>▸ Audit. |

## Outpatient departments

| | Standard | Measurement criteria |
|---|---|---|
| 10.9 | Children are seen in designated children's clinics. Where this is not possible, cases are scheduled with consideration for the needs of children and carers. | ▸ Examples of clinics.<br>▸ Evidence of measures in place working towards designated clinics where volume is sufficient.<br>▸ PREMs are monitored. |

## Emergency

| | Standard | Measurement criteria |
|---|---|---|
| 10.10 | The critically ill child with an immediate life-threatening condition is assessed by a senior clinician and the decision to operate or transfer is made promptly, according to network arrangements.<br><br>**Best practice**<br>Consultant-led multidisciplinary team resuscitation, assessment and decision of definitive management. | ▸ Audit of outcomes, untoward incidents and transfers. |

| | Standard | Measurement criteria |
|---|---|---|
| 10.11 | For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. | ▸ Audit of time intervals between admission, decision to operate and operation. |
| 10.12 | At any time, the ED rota includes sufficient cover for emergencies in children. | ▸ Example rotas. |
| 10.13 | Children have access to a child-friendly environment in EDs. | ▸ Description of facilities. |
| 10.14 | Emergency surgery is normally undertaken in hospitals with comprehensive paediatric facilities, 24/7 paediatric cover, children's nursing support and paediatric-competent anaesthetic support.<br><br>**Best practice**<br>There is always at least one member of emergency staff on site who is trained and competent in APLS/EPLS or equivalent. | ▸ Description of service.<br>▸ Audit. |
| 10.15 | Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available. | ▸ Evidence of child-specific training and CPD. |
| 10.16 | When transfer is required, this is supervised by senior medical and nursing staff. Timely decisions are made and implemented regarding transfer and escort methods. | ▸ Transfer policy or protocol.<br>▸ Audit of transfers including duration and outcome. |
| 10.17 | The trust/network has a policy to support surgeons and anaesthetists undertaking life-saving interventions in children who cannot be transferred or who cannot wait until a designated surgeon is available. | ▸ Written policy in place.<br>▸ Notify such cases to the trust for audit purposes. |
| 10.18 | All hospitals admitting emergencies have the required resources and equipment to stabilise and resuscitate a child including infants at all times.<br><br>**Best practice**<br>Board member for children takes responsibility in conjunction with ED and consultants in paediatrics and anaesthesia. | ▸ Adequacy of resources assessed annually. |

| | Standard | Measurement criteria |
|---|---|---|
| 10.19 | Emergency theatres and recovery are staffed by a paediatric-competent theatre team.<br><br>**Best practice**<br>All theatre staff have child-specific training. | ▸ Evidence in appraisals. |
| 10.20 | Access to children's critical care facilities is available at all times.<br><br>Agreed protocols for transfer to these facilities are in place.<br><br>**Best practice**<br>Fully staffed high dependency unit (HDU) beds available 24/7 on site.<br><br>Formal arrangement with regional paediatric intensive care unit (PICU) for acceptance and transfer of critically ill children, including retrieval. | ▸ Delays in acceptance and transfer of critically ill children audited. |
| 10.21 | Where children present to an ambulatory/day-case facility, there is a robust procedure in place for assessment and transfer if required.<br><br>**Best practice**<br>Children have access to a senior paediatrician, a surgeon and anaesthetist.[20]<br><br>Written protocol for assessment and transfer of emergency surgical children. | ▸ Efficiency of assessment and transfer pathway. |
| 10.22 | There is trust/network/health board-wide audit of emergency surgery in children. Emergency children's surgical practice is audited at least annually using routinely collected data. Examples: Time between admission/decision to operate and the operation taking place, length of stay, morbidity and mortality. Audit should include children's surgical transfers and untoward incidents including unplanned re-admissions and unplanned admissions to a critical care unit.<br><br>Emergency children's surgery is included in inter-network audit of children's surgery.<br><br>**Best practice**<br>There should be common and agreed methods of data collection that are easily comparable between trusts. | ▸ Regular audit, outcomes discussed at board level with evidence of feedback to improve practice. |

## Day surgery

| | Standard | Measurement criteria |
|---|---|---|
| 10.23 | Children's surgery is provided on a day-case basis wherever practical. | ▸ Example day case lists.<br>▸ Regular audit. |
| 10.24 | A named consultant surgeon is responsible for the care of the child but can delegate to other grades as appropriate. | ▸ Named consultant responsible for each case.<br>▸ Regular audit. |
| 10.25 | A paediatric-trained consultant anaesthetist is present for day-case surgery but can delegate to other grades as appropriate. | ▸ Copies of rotas. |
| 10.26 | Parents and carers are given clear instructions on follow-up and arrangements in the case of postoperative emergency. | ▸ Copies of information. |
| 10.27 | A minimum of two registered children's nurses are present in day surgical areas. | ▸ Copies of rotas. |
| 10.28 | The outcomes of day-case activity is audited and reviewed. | ▸ Regular audit and review. |
| 10.29 | Processes are in place to facilitate transfer within the network should complications arise. | ▸ Description of process. |

The following additional standards apply to centres undertaking day-case paediatric surgery **without inpatient paediatrics:**

| | Standard | Measurement criteria |
|---|---|---|
| 10.30 | Elective surgery and anaesthesia is only delivered by consultant surgeons and anaesthetists experienced in the condition. | ▸ Example rotas. |
| 10.31 | The surgeon and anaesthetist remain in the hospital until arrangements have been made for the discharge (or transfer) of all patients under their care. | ▸ Monitored on a ward-by-ward basis. |
| 10.32 | At least one member of the team has current advanced paediatric life support training. All team members have up-to-date basic skills for paediatric resuscitation. | ▸ Appraisal.<br>▸ Evidence of training.<br>▸ Examples of rotas. |
| 10.33 | At least one member of the team with up to date basic skills for paediatric resuscitation is present throughout the period the child is in the unit. | ▸ Example rotas. |

| | Standard | Measurement criteria |
|---|---|---|
| 10.34 | A neighbouring children's service takes formal responsibility for the children being managed in the unit. Every effort is made to ensure this neighbouring unit is geographically close enough to ensure support is practical. | ▸ Formal agreement in place. |
| 10.35 | Agreed and robust arrangements are in place for paediatric assistance and transfer if required. | ▸ Formal arrangements in place and widely known. |

# 11 Glossary

| | |
|---|---|
| APLS | Advanced Paediatric Life Support |
| ATLS® | Advanced Trauma Life Support® |
| ARCP | Annual review of competence progression |
| Advanced level | See APLS/ATLS® |
| Appraisal | Formal review of a clinician's progress |
| CRB | Criminal records bureau check |
| CPD | Continuing professional development |
| Child protection | See safeguarding |
| Consent | Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment.[21,22] |
| Day case | Surgery which is performed on a 'same day' basis. The patient may remain in hospital for up to 23 hours. It is artificial to think that the patient will leave hospital within, for example, 8 hours. |
| EPLS | European Paediatric Life Support |
| 'Emergency' surgery | Surgery that cannot be delayed, for which there is no alternative therapy or surgeon, and a delay could result in death or permanent impairment of health.[23,24] |
| Enhanced CRB | See CRB |
| GMC | General Medical Council |
| GPS | General paediatric surgery |
| HDU | High dependency unit |
| Local provider network | An interconnected system of service providers, allowing collaborative working, agreed standards of care, routes of communication and agreed threshold for patient transfer.[1] |
| MAST | Mandatory and statutory training |
| MDT | Multidisciplinary team |
| M&M | Mortality and morbidity |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |
| NICE | National Institute for Health and Clinical Excellence |
| PICU | Paediatric intensive care unit |
| PILS | Paediatric Immediate Life Support |
| PREMs | Patient-reported experience measures |

| | |
|---|---|
| PROMs | Patient-reported outcome measures |
| Parent | Used as shorthand for clarity to mean the primary adult carer or legally appointed carer |
| Revalidation | Process of regulation for all doctors that practise medicine in the UK |
| SAS | Specialty and associate specialist doctor; a doctor of experience and seniority who is not a consultant. See senior clinician. |
| SHMI | Summary hospital mortality indicator |
| SIGN | Scottish Intercollegiate Guidelines Network |
| ST3 | Trainee specialist who has passed postgraduate examination to enter higher training. In third postgraduate training year |
| Senior clinician | A consultant or SAS doctor,[20] distinguished from a trainee grade. See ST3. |
| Supervision | Clinical, to distinguish delivery of service from supervised. |
| Safeguarding | The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.[25] |
| Strategic clinical network | Centrally hosted and funded groups to help local commissioners of NHS care to reduce unexplained variation in services and encourage innovation.[26] |
| Sub-specialty | Specialty children's surgery, (eg orthopaedics) to distinguish from general paediatric surgery. See GPS |
| Tertiary | A specialist children's hospital. To distinguish from secondary (general hospital) and primary (general practice) levels of care. National services are sometimes termed 'quaternary'. |

# 12 Further reading

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