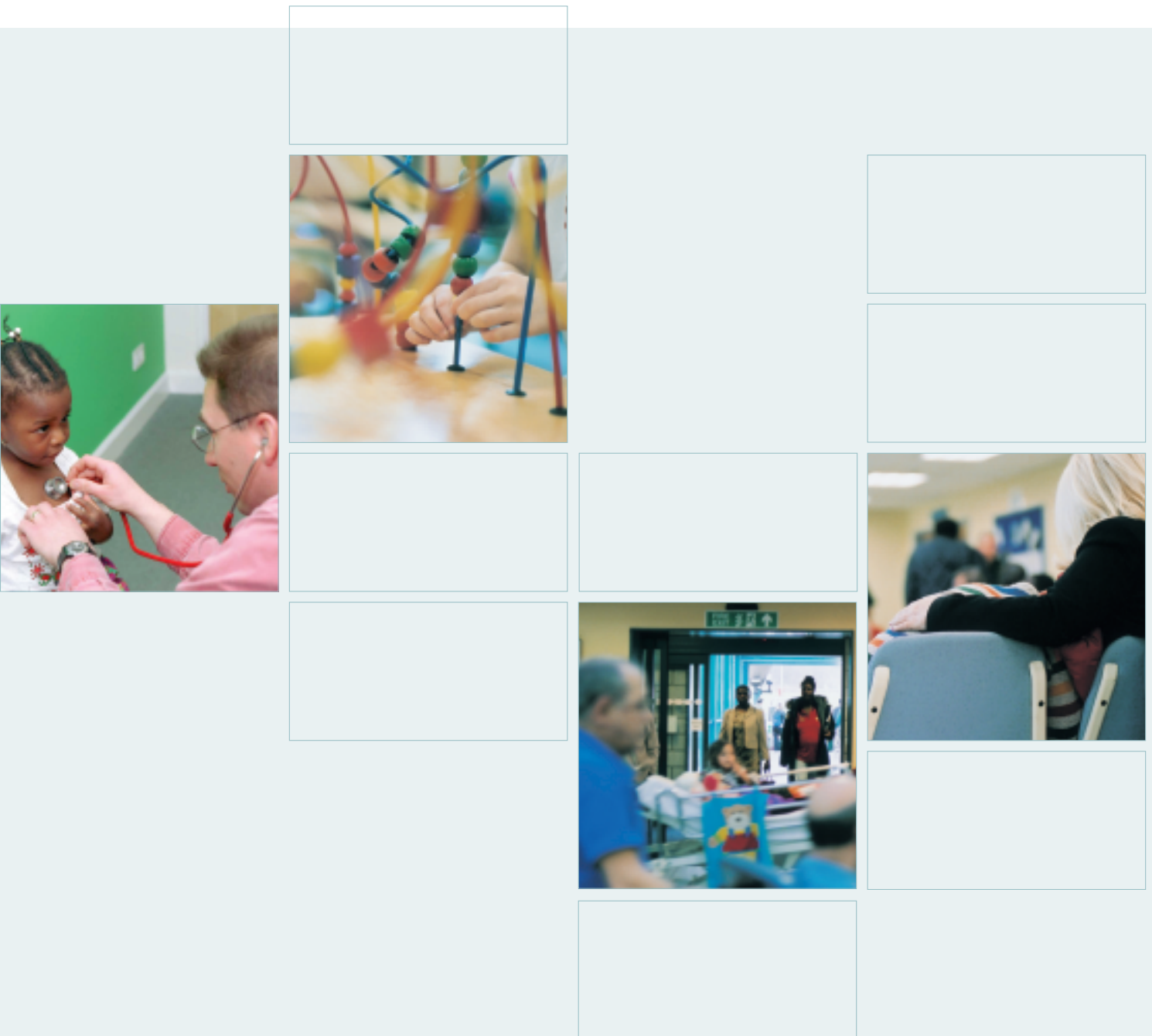


Improving services for children in hospital



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The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales. In England, the Healthcare Commission is responsible for assessing and reporting on the performance of NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. The Healthcare Commission also encourages providers to continually improve their services and the way they work. In Wales, the role of the Healthcare Commission is more limited and relates mainly to working on national reviews that cover both England and Wales, as well as our annual report on the state of healthcare. In this role, the Healthcare Commission works closely with the Health Inspectorate Wales, who are responsible for the NHS in Wales, and the Care Standards Inspectorate Wales, who are responsible for independent healthcare in Wales.

The Healthcare Commission aims to:

- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public
- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in our decision making, and consultative about our processes

Executive summary

The Government published the hospital standard of the National Service Framework (NSF) for Children and Young People in 2003. It was, in part, a response to the Kennedy Report into events surrounding the deaths of children who underwent heart surgery at the Bristol Royal Infirmary. The standard established wide-ranging and important requirements for services for children in hospital, to be implemented over 10 years.

In 2006, the Healthcare Commission carried out a major review of services for children in hospital. The review assessed whether hospitals were meeting or making progress towards key requirements of the hospital standard.

Each organisation providing hospital care to children received a detailed local assessment. The results of these assessments were based on a four point scale of excellent, good, fair and weak. Four per cent of organisations received an overall score of 'excellent' and 21% scored 'good'. However, 70% of trusts scored 'fair' and need to make a number of improvements. Five per cent were scored as 'weak': these trusts do not meet a significant number of standards such that there are areas of concern.

Individual results from these assessments are available on our website at www.healthcarecommission.org.uk. Patients and the public can use this information to check whether their local hospital provides a safe, child-friendly service.

Key findings

The review highlighted serious concerns in relation to the quality and safety of care at a small number of trusts. Generally, we found that trusts have made poor progress in meeting the broader needs of children. There has been progress in meeting environmental requirements, such as separate areas for children, appropriate security and play facilities, but this needs to be reflected more widely across different services in hospitals.

Quality and safety of medical and surgical care

Children have distinct needs when it comes to life support and medical and surgical treatment. As care becomes increasingly specialised, it is important that staff coming into contact with children are appropriately trained and work with enough children every year to maintain their skills in treating them.

There have been improvements in this area during the last decade and we have found that, in most trusts, appropriate arrangements are in place. However, there are serious risks in a significant minority of trusts that must be addressed.

The review found that, in 8% of trusts, surgeons carrying out planned surgery did not work enough with children to maintain their skills to work with very young children. In addition, 16% of paediatric inpatient units carried out less work with children than the recommended minimum professional level.

In a small number of hospitals (12%), there was insufficient cover during the day to ensure that effective paediatric life support was

available in serious emergencies. At night, this figure rose to 18%. This is an area of high risk and requires urgent attention locally. Some trusts did not have a sufficient number of surgeons or anaesthetists working in children's emergency care to maintain a rota around the clock. Some accident and emergency (A&E) departments treated only small numbers of children, and many general surgeons and anaesthetists on rotas for emergency care worked only occasionally with children. This affects the ability of hospitals to deal safely with serious emergencies in young children.

The treatment of pain in A&E departments has improved in recent years, but in a large number of services, particularly those providing day case and outpatient care, there was an insufficient number of staff trained in the management of pain in children.

Local strategic health authorities, with commissioners and trusts, must ensure that there is a network of sustainable and safe services for children in each region. Such networks must have access to staff who are trained and who have sufficient recent experience of working with children. To achieve this, some services may need to merge or be moved to different local or regional trusts. Increased collaboration is needed between local trusts and with regional specialist trusts. Regional specialist trusts should provide refresher training for staff in local trusts and deliver more planned care for children by 'outreach' in local trusts.

Meeting the broader needs of the child

Children should be active participants in decisions about their treatment and, where possible, they should be able to exercise

choices. They have a basic need for play, which can also help them understand their treatment and speed up recovery. Also children, more than most other groups of patients, need to be kept safe.

The review found that progress in meeting these goals was generally poor. The broader needs of children were not being recognised or given proper priority in many trusts.

Child protection remains a major risk. Although 60% of nurses had relevant training in basic child protection, 58% of the services used by children did not meet the necessary training standards. Trusts must take action to assure themselves and the populations they serve that staff in all services are suitably trained to raise concerns about the protection of a child.

Many children had a poorer experience of hospital than they should because of a lack of training of staff in communication (only 24% of nurses and 7-9% of surgeons and anaesthetists were formally trained) and highly variable access to staff who specialise in play. Trusts need to recognise the benefits of play and communication and give these a much higher priority.

Child-friendly and child-only environments

The hospital standard states that the care of children and young people in hospital should be provided in buildings that are accessible, safe, suitable and child and family-friendly. It also states that children should be treated in separate facilities, away from adults, wherever possible.

The review found that progress had been made in this area. However, it needs to be sustained and extended more widely to all services in hospitals.

Most (79%) services used by children were making progress towards meeting environmental standards, but few (14%) met them in full. Outpatients' departments particularly needed to improve.

We found that the needs of children were far better met when they were cared for in child-only services. Trusts were very good at ensuring that children requiring inpatient care were admitted into child-only wards (99%). But this achievement did not extend to other services such as A&E (38%) and outpatients' departments (46%). In outpatient, day case and A&E facilities, the proportion of children cared for in child-only services varied significantly across trusts.

The review found that some hospitals could make far better use of their existing children's services (for example, children's outpatients' departments). Others need to develop new child-only services or bring all of their mixed services (used by both adults and children) in line with the hospital standard. Trusts should review the locations at which care is provided for children in their hospitals, and consider reducing their number. They must develop a model of service that will enable them to meet the hospital standard in all areas.

Governance and leadership

One of the main challenges for trusts participating in the review was identifying all of the services used by children, all of the staff (including surgeons and anaesthetists) who worked with children and their level of training. These elements of governance are extremely important because they are the first steps to ensuring that the requirements of the hospital standard are met.

On balance, the review found that the needs of children were better met when they were cared for in services managed by paediatric directorates. Evidence from the trusts that we visited and the results of the review showed that some boards of trusts were still not recognising children's care as a matter for the board or for the trust as a whole. Leaders in other directorates need to ensure that improving the care of children is integral to their plans. Each trust needs to apply greater scrutiny to services provided to children outside the paediatric department.

Key recommendations

The boards of hospital trusts must assure themselves and their local population that they are making progress in relation to the hospital standard. They need to be sure that all the services that they provide to children:

- are of high quality and clinically safe, have appropriate levels of staffing, and are provided by appropriately trained staff who maintain their skills in surgery, life support and the management of pain
- meet the requirements for effective child protection
- address the broader needs of children for communication and play
- are delivered in child-focused environments

Trusts should check that standards are being met in all mixed child and adult services, as well as child-only services.

If they have not done so already, boards of hospital trusts can compare their performance with that of other trusts to identify areas for improvement. This information is available on our website. There are a number of questions at the end of this report that trusts could also consider locally as part of their processes for assurance.

Commissioners and strategic health authorities should:

- ensure that there is a sustainable regional network of services for children by reviewing the level of work carried out by, and the locations of, hospitals that provide inpatient care and planned and emergency surgery (particularly for young children). If necessary, services should be moved between local trusts or to regional trusts. Commissioners and strategic health authorities must work together to achieve this, notwithstanding reforms such as payment by results and patient choice
- establish clinical networks and improve 'outreach' from regional centres, particularly in surgical specialities, to maintain local expertise
- support the training of staff in trusts by giving proper priority to training in the care of children in programmes of development, and by identifying appropriate locally provided courses
- strategic health authorities responsible for managing the performance of NHS trusts should ensure that trusts have an action plan addressing all areas of weakness identified by the Healthcare Commission

Professional bodies should:

- press for the improvement of services for children, in line with the recommendations in this report, and promote local leadership among their members
- ensure that the requirements for pre-registration training include appropriate training for, and exposure to, paediatric cases, including paediatric life support and basic communication skills
- be clear about the minimum requirements for initial and refresher training in the care of children and what is required for professionals to maintain their competence to work with younger children. This should be communicated to members and reinforced during all visits by professionals to trusts

Next steps

The Healthcare Commission has already worked with the 10% of trusts that are, based on the findings of this review, most in need of improvement. These trusts have drawn up action plans to address areas of weakness identified in their individual assessments. However, this report highlights a number of continuing concerns. We expect all trusts, commissioners and strategic health authorities to ensure that its recommendations are met in full.

All trusts should develop plans based on the areas of weakness identified by this review. Boards are responsible for ensuring that these plans are achieved. Boards of foundation trusts are also required to inform Monitor if the trust is at risk of failing to improve in any areas of concern identified by this review.

Strategic health authorities have a responsibility to hold trusts (except foundation trusts) to account for improvements. They, with commissioners, will be expected to lead planning at a regional level.

The Healthcare Commission will continue to promote improvement by collecting key information identified from this review each year from 2006/2007. This information will be collected through the child health mapping project. It will include particular aspects of training, the number of children surgical staff work with, the availability of children's nurses in outpatients' departments and access to staff who specialise in play. Indicators to measure performance will be created from this information, allowing the Commission to identify improvement in key areas. These indicators will also contribute to our assessment of performance in relation to standards, and will be used to target further activity and planning for improvement.

In addition, our local assessment managers will check that trusts are addressing poor performance and our regular discussions with strategic health authorities will ensure that our recommendations are accounted for in their systems of performance management.

Introduction

Children are healthier than ever before and death in childhood is rare. The rate of infant death in England and Wales fell to its lowest recorded level in 2004, and there have been considerable reductions in unintentional injury, which is the most common cause of death among children.^{1,2} The national programme of immunisation has increased the uptake of a number of vaccinations, with cases of diseases such as polio, diphtheria and whooping cough now occurring only very rarely.³

There remains, however, a substantial difference in rates of death in children from different social classes.^{1,2} The rise in the prevalence of childhood obesity is well-documented, and Britain has among the highest percentage of children who consume alcohol in the world.¹ The number of children with disabilities also increased by 62%

between 1975 and 2002. This is, in part, associated with the increasing number of infants surviving premature birth, birth with abnormalities, or other health problems.⁴

These changes in children's health mean that the reasons why they access healthcare are changing.

Although parents often manage their child's illness, children and young people are more frequent users of all types of healthcare than adults. A large number of children are treated in hospital every year (Table 1), and there is evidence that this number is increasing.^{5, 6, 7, 8} Nearly three million children (equivalent to 28% of all children in England) attend accident and emergency (A&E) departments in hospitals in England each year, accounting for more than 25% of patients seen in A&E nationally.

Table 1: Number of children treated in English hospitals each year

	Number of children (aged 0 to 16) treated each year*	As percentage of child population of England*
Attendances in A&E	2.9 million	28%
Inpatient (overnight) admissions	700,000	7%
Day cases	300,000	3%
Operations	500,000	5%
Attendances as outpatients	4.5 million	45%*

*A child seen in one service in hospital may be counted again in another service. For example, a child seen in A&E or outpatients' departments may then be admitted and have an operation. The same child may also come back to the same hospital service a number of times. This is particularly true of outpatients' departments and, to a lesser extent, other services. Therefore, 45% of children will not have been seen once in outpatients, but a smaller percentage will have been seen more than once.

Background

Children have different needs to adults, and hospitals must take this into account in order to provide safe and child-friendly care. Nearly 50 years ago, the Platt report⁹ focused on the fact that children in hospital cannot be treated in the same way as adults. Children, particularly infants and younger children, suffer from a different range of diseases and disorders from those commonly seen in adults and have different anatomy and physiology, which change as they grow. Their skills in communication and their ability to choose and consent to treatment are different. They are also more vulnerable to intentional harm than many adults.

A number of reports have raised concerns about the quality and safety of services for children in hospital. The inquiry into the death of Victoria Climbié¹⁰ found that established good medical practice and straightforward procedures on how to respond to concerns of deliberate harm to a child were not followed. It called for staff to be trained adequately to carry out their duties in the care and protection of children. The Kennedy Report¹¹ into events surrounding the deaths of children who underwent heart surgery at the Bristol Royal Infirmary found that the quality of care was less than it should have been, services were fragmented, the rights and vulnerability of children were overlooked, and open and honest relationships with children and parents were lacking. Services treated children as if they were simply 'mini-adults', needing "smaller beds and smaller portions of food", and made little effort to tailor explanations to the understanding of children or their parents. Staff were skilled in treating adults but had no specific training in treating children, and

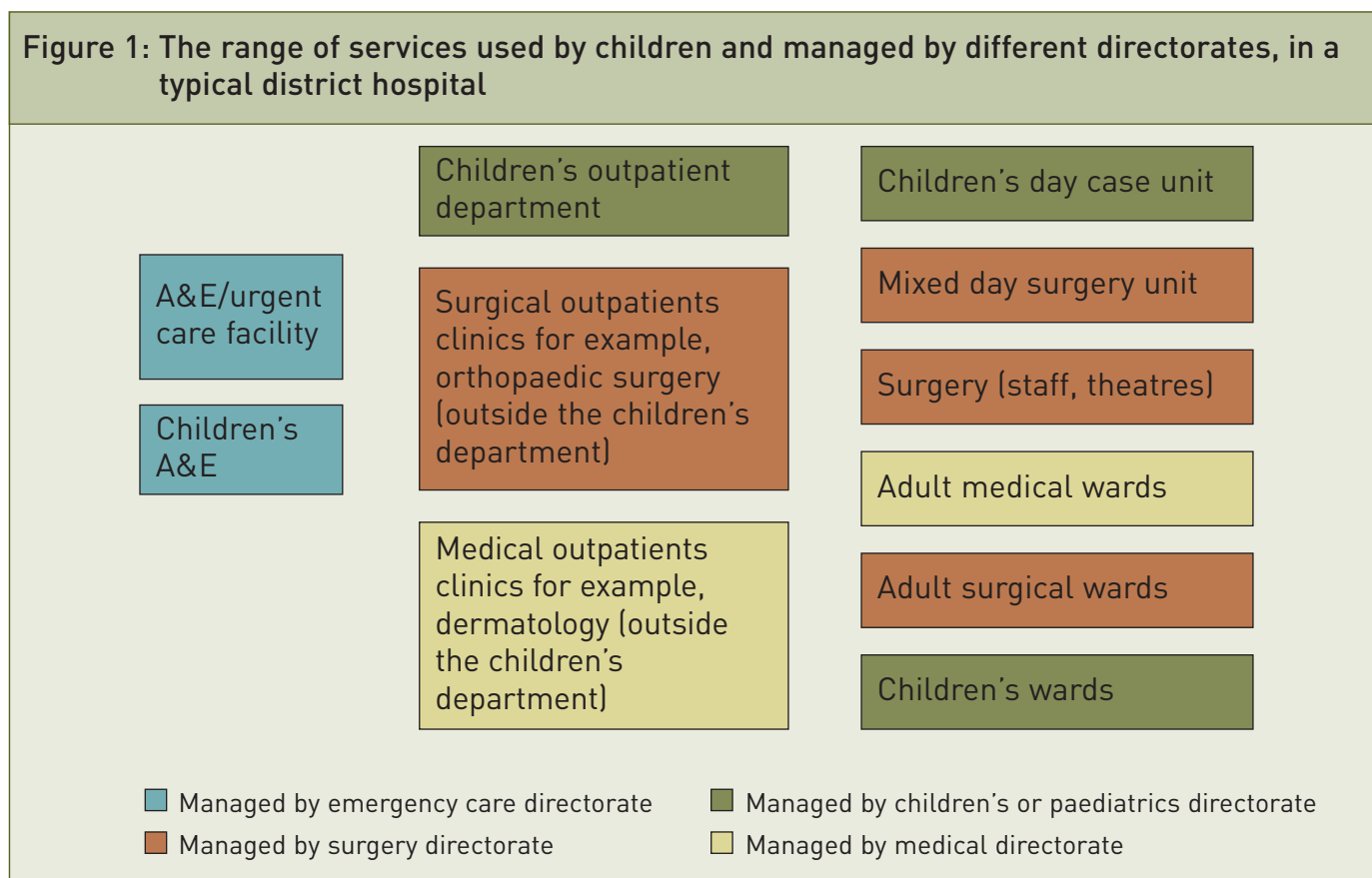
facilities were designed with little acknowledgement of the needs of children.

Figure 1 shows how different directorates often manage the various services used by children in hospital. This means that different parts within a hospital need to work together to deliver and improve services for children – this includes directorates, such as surgery, in which children are not the primary focus. The Kennedy Report found that this joint working was lacking: services were fragmented and children were not considered to be a matter for the board or the trust as a whole. Services outside the remit of the children's or paediatric directorate were not addressing the needs of children.

In 2003, in part as a response to the Kennedy Report, the Government published the hospital standard of the National Service Framework (NSF) for Children and Young People.¹² The standard established wide-ranging and important requirements for services for children in hospital, to be implemented over 10 years.

The standards of the NSF are part of a broader programme of reforms, set out in *Every Child Matters: Change for Children*.¹³ The objective of the reforms is for all children and young people to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing



The reforms are dependent on the input of health services, the framework for which is well established in the NSF, *Every Child Matters*, the Government white paper *Our Health, Our care, Our Say*, the Children Act 2004 and the Childcare Act 2006.

Reflecting concerns in the Kennedy Report about fragmented hospital services, the hospital standard covers all departments and services that deliver care to children in hospital, not just children's wards or departments. This includes any service where children are treated alongside adults (but does not include maternity services, which come under another standard). It requires all trusts to designate a board member to be responsible for all services for children throughout the hospital.

The standard has three parts:

- the quality and safety of care
- child-centred care, which addresses the broader needs of children
- the hospital environment

There is a strong emphasis in the hospital standard on the need to improve the training of staff. It states that "all staff treating or caring for children and young people should have appropriate training, and should undergo regular updating and refreshment of skills. This training should cover both the technical clinical skills and the personal and communication skills necessary to treat children ... properly".

About the review

The Healthcare Commission's improvement reviews look at whether healthcare organisations are improving the care and treatment they provide to patients. They focus on aspects of health and healthcare where there are substantial opportunities for improvement, helping organisations to identify where and how they can better perform. They assess organisations by measuring performance on key questions that are important to patients and the public and those delivering services.

In 2005/2006, the Healthcare Commission carried out improvement reviews of services for children in hospital, substance misuse, tobacco control and adult community mental health. The results of these reviews contributed to our annual performance ratings of the NHS, published in October 2006. In 2006/2007, improvement reviews will form part of a wider programme of service reviews, looking at services to treat people with heart failure and diabetes, acute inpatient mental health services and maternity services, as well as a further review of substance misuse services.

There are two parts to an improvement review:

- a comprehensive assessment of the performance of each organisation taking part in the review
- follow-up work targeted specifically at those organisations in greatest need of improvement

Our review of services for children in hospital focused on elements of the hospital standard in which hospitals should have already made

progress. Our decision to carry out a review of this area of healthcare was based on the findings of earlier reports, which clearly highlighted the need for improvement. The clear standards and expectations for hospital services set out by the NSF¹² also provided a strong basis against which services could be assessed.

The review asked five questions:

- do children have access to child-friendly or child-only facilities?
- do children access local services?
- is there appropriate emergency cover and are services covered by appropriate staff, such as children's nurses, staff who specialise in play and pain teams?
- are staff trained to work with children?
- are services organised so that staff have sufficient exposure to children to maintain their skills?

In any improvement review, the key questions asked must be important to patients and the public and those delivering services, and must be concerned with the areas most in need of improvement. To ensure this, we worked with 20 hospital trusts and a group of more than 30 national experts, including patients' representatives and healthcare professionals. To find out more, visit our website at www.healthcarecommission.org.uk/improvementreviewchildrens.

The resulting key questions are important themes in the hospital standard and are also supported in a range of other professional publications.^{14, 15, 16}

The review covered six types of services provided in hospitals:

- emergency care facilities (such as A&E departments and short term assessment units)
- day case care (for patients who do not need to stay overnight in hospital after surgery)
- outpatients' departments
- inpatient care (wards where patients stay overnight)
- emergency surgery
- planned (elective) surgery

A large proportion of children access mixed services with adults, rather than children-only services. Reflecting this, the review looked at every location in which children are treated. For example, we looked at the quality and safety of care in A&E departments for children and in A&E departments attended by patients of all ages. We covered all services used by children aged between 29 days and 16 years old*.

In January 2006, the review collected data from all organisations that provide acute hospital care for children in England, where children account for more than 4% of the workload. This included 157 hospital trusts, two primary care trusts (PCTs) and one partnership trust. On the basis of this data, we were able to assess whether hospitals were meeting or making progress in relation to the hospital standard. Each organisation providing hospital care received a score on a four-point scale, from 'weak' to 'excellent', for each aspect of the review and received a detailed assessment report in August 2006.

*Children under 29 days of age were excluded because neonatal care was not covered in the review. One question about beds for young people aged 13 to 18 was included. Surgical questions covered children up to 12 years because our reference group deemed that surgery involved increased risks for children up to this age.

Overall results

Four per cent of organisations received an overall score of 'excellent' for the review and 21% received a score of 'good'. These organisations were meeting most standards and making good progress on improving their services for children. However, 70% of trusts scored 'fair' and therefore needed to make a number of improvements. Five per cent were scored as 'weak' because they were not meeting a significant number of key standards, such that there were areas of concern.

Across all the services assessed in the review, inpatients' services provided the best care to children, with 71% scoring 'good' or 'excellent'. This achievement is to be welcomed, but good practice needs to extend to other services. For both emergency and day case services, 28% of organisations scored 'weak' and 46% of organisations scored 'weak' for outpatients' services. The results for training among surgical and anaesthetist staff were also of concern: 28% of organisations scored 'weak' for training of staff in emergency surgery, and 22% scored 'weak' for planned surgery.

This report

This report presents a national picture of services for children in hospital. It looks behind the scores of individual trusts, to draw out the most important messages and areas for improvement throughout England. Our findings are organised into three themes, reflecting the parts of the hospital standard:

- the quality and safety of care provided
- how well hospitals provide child-centred services to meet the broader needs of children
- the child-friendliness of environments

It is written for a wide audience, including the public, boards of hospital trusts, managers and clinical directors, commissioners of services for children, strategic health authorities and professional organisations.

Individual results for all trusts that participated in the review are available on our website at www.healthcarecommission.org.uk/improvementreviewchildrens. Members of the public, children, young people and patients can use this information to check whether their local hospital provides a safe, child-friendly service.

Our website also has information on how the Healthcare Commission is assessing the performance of healthcare organisations in relation to the other 10 standards of the NSF for Children and Young People.

Key findings

The quality and safety of services

Children have distinct needs when it comes to life support and medical and surgical treatment. Younger children often have different medical and surgical conditions from adults, and the way they present (how their symptoms appear) is often different and harder to diagnose. There are differences in the way adults and children, particularly younger children, are treated. For example, there are differences in advanced emergency life support techniques, physical examination, use of medicines, management during and after surgery, and the management of pain.

Parents want their children to have high quality, up-to-date and evidence-based care in hospital. As care becomes increasingly specialised, it is important that staff coming into contact with children are appropriately trained and work with enough children every year to maintain their skills in treating them. This has implications for where and how services are provided.

There have been improvements during the last decade. For example, there has been an improvement in the treatment of children's pain in A&E departments,¹⁷ a reduction in the number of anaesthetists carrying out occasional practice with infants,¹⁸ and an increase in the number of hospitals with appropriate cover for paediatric emergencies.¹⁹ However, we found that, while most trusts have appropriate arrangements in place, considerable risks were present in a significant minority.

Planned surgery on young children

The review found that, in some trusts, surgeons and anaesthetists providing planned (elective) surgery may not get sufficient exposure to children to maintain their skills to work with young children.

Young children cannot be treated surgically as if they were 'mini-adults'. Some children's surgical disorders are rarely encountered in adults. Operative surgery and anaesthesia in infants and young children differ in many ways, including airway access and management, the handling of tissue, attention to fluid balance, incision and wound closure. These differences extend to care provided to children before and after an operation, particularly in relation to the management of fluids and control of pain.¹⁴

The 1999 report of the National Confidential Enquiry into Peri-Operative Deaths (NCEPOD)¹⁸ found that surgeons and anaesthetists were doing most things well. For example, there were no deaths after common childhood operations to remove appendixes or tonsils. However, the NCEPOD did find instances of surgeons and anaesthetists carrying out surgery only occasionally on young children and infants, which can be high risk. An earlier (1989) report by the NCEPOD²⁰ recommended that there should be no occasional work carried out with children except in life-threatening emergencies. It also stated that the outcome of surgery and anaesthesia in children is related to the experience of the clinicians involved.

Professional recommendations state that surgeons with an expertise in adults can undertake common and minor planned surgery on children over the age of eight.²¹ However, surgeons working with younger children need specific training and need to ensure that they work with sufficient numbers of children to maintain their skills. It has been suggested that a surgeon working in the larger specialities* should complete the equivalent of 100 cases with children each year, in order to maintain their skills to carry out planned work with younger children.^{14, 22} If a surgeon carrying out planned surgery on children works with fewer than 100 children a year, their trust should find out the age of the children and assure itself that the surgeon is operating within their abilities.

There is evidence that giving anaesthetic to infants and children under the age of two carries increased risk. Recommendations by the NCEPOD in 1999 sought to reduce the number of anaesthetists working with infants.^{14, 18, 23, 24} If an anaesthetist works infrequently with very young children, trusts should look carefully at whether the anaesthetist remains competent to do so, particularly if they work infrequently with children overall.

We analysed hospital episode statistics from the Department of Health to find out how many surgical teams in a trust carried out more than 100 procedures each year on children aged 0 to 12. We included all surgical specialities and all teams carrying out planned (elective) work.** For comparison, we also asked trusts to identify all consultant anaesthetists who worked with children aged

0 to 12, and the number who carried out more than 100 anaesthetics each year on children aged 0 to 12.

In 11 trusts (8%) that provided planned surgery to children, no consultant surgical team carrying out planned work completed more than 100 procedures a year. This would be acceptable if all the children treated in these trusts were older children and surgery was not complex. However, no surgical team at these trusts had a sufficiently high paediatric workload to carry out planned work with younger children (Figure 2).

Twenty-eight trusts (21%) that provided planned anaesthesia to children said that none of their consultants anaesthetised more than 100 children a year (Figure 2). These trusts need to check that their anaesthetists can maintain the skills to work with children and that arrangements are in place specifically for the anaesthesia of infants and very young children up to the age of two.

Across England, 84% of consultant surgical teams and 77% of consultant anaesthetists who carried out planned work with children worked with fewer than 100 children aged 0 to 12 each year. Many of these consultant surgeons and anaesthetists were likely to be working only with older children. However, given the overall number of teams in this position, some general, orthopaedic or ear, nose and throat surgeons are likely to be doing occasional work with young children or infants.

If surgeons and anaesthetists who carry out planned surgery are working with small numbers of children, trusts need to ensure that

*This includes general, orthopaedic or ear, nose and throat surgery.

**We counted both the emergency and the planned procedures carried out by these teams and included all their work in different trusts.

they are providing the service safely. This means that:

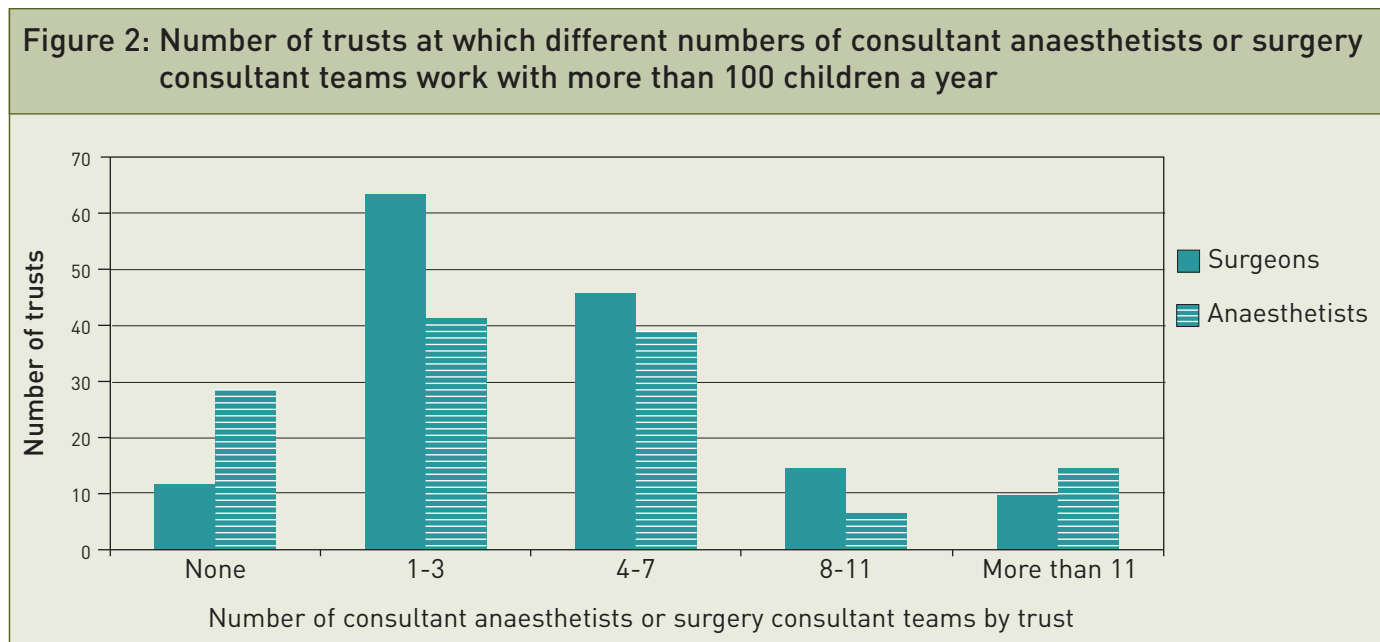
- it is clear which surgeons and anaesthetists are able to work with young children (up to age eight for surgeons and up to age two for anaesthetists)
- these staff have appropriate training, including refresher training, and are considered competent
- surgeons who work with small numbers of children are not working with younger children, except in life-threatening emergencies

If possible, trusts should reduce the number of surgeons and anaesthetists carrying out planned work with children, particularly young children and infants, so that fewer staff share the workload and therefore can maintain their skills. This and other ways of organising planned surgery for children are discussed below.

Safer planned surgery for children

One way to increase the exposure of particular staff to planned surgery with children is to set up surgical lists for children. This allows staff to focus on their needs. The extent to which different trusts adopted this approach varied considerably*:

- 79% of children receiving planned general surgery were on child-only lists. However, at 25% of trusts, no children were treated on child-only lists
- 54% of children receiving planned orthopaedic surgery were on child-only lists. At 51% of trusts, no children were treated on child-only lists
- 52% of children receiving planned ear, nose and throat surgery were on child-only lists. At 39% of trusts, no children were treated on child-only lists



*We asked trusts to count all children on children-only lists, as well as lists intended for children (in which children are operated on at the start of the list, but adults may be operated on at the end).

Some trusts need to revisit their procedures for booking theatre lists and work with surgical teams to create lists specifically for children or containing mostly children.

However, surgical sub-specialisation may be one reason why so many different surgeons carry out low levels of planned surgery on children (and why it is hard to create a list specifically for children at some trusts). For example, a general surgeon may be an expert sub-specialist in conditions of the intestine and consequently may do little other general surgery (such as vascular or breast surgery). Sub-specialisation increases the number of surgeons working with children because each surgeon is a specialist in a narrower area of practice. Consequently, each surgeon works with a smaller number of children. This arrangement does not help trusts to establish and maintain a focused group of surgeons who are competent to work with young children within each speciality. There needs to be further professional debate on the best model of surgical care for children.

Even trusts that have put such measures in place may find it hard to provide a sustainable service for young children because fewer and fewer young children are being operated on in local hospitals. The number of surgical episodes involving children in district general hospitals decreased from more than 410,000 children under 18 years in 1994/1995 to 325,000 in 2004/2005.²³ Some, but not all, of this surgery has shifted to regional specialist trusts: these trusts are now responsible for 39% of children's surgery compared with 24% in 1994/1995. The shift has been greatest for children up to the age of four.

In addition, some surgery is simply not being carried out at all any more. For example, fewer children now receive surgery to remove tonsils or adenoids, insert grommets or carry out circumcisions for health reasons. These types of surgery were traditionally carried out in local district hospitals.

As new surgical procedures are developed, it may be appropriate that these are carried out at a regional level, not locally. However, the shift in surgery to specialist units, along with increasing sub-specialisation at local hospitals, will make it increasingly hard for local surgeons and anaesthetists to maintain their skills and confidence to treat younger children. As a result, more children will in turn be referred to specialist units. This increases the inconvenience for children whose condition could be treated locally. It also threatens the ability of local hospitals to provide a safe emergency service, as surgeons and anaesthetists become de-skilled in the care of younger children.^{16, 25, 26, 27, 28} This issue is discussed later in the report, in relation to the provision of emergency care for children.

Networks for planned surgery

Some planned surgical services do not treat enough children for staff to maintain their skills to work with young children. A decision needs to be made about the future of such services, to ensure that they are safe.

The service could be supported by a clinical network of local and regional providers of children's surgery, as recommended in a number of publications.^{1, 14, 16, 21, 22, 23, 25, 29, 30}

The key features of such a network should include:

- an agreement about the respective roles of local trusts and regional trusts for each surgical speciality, in terms of what surgery will be provided by which trust, where and how diagnosis takes place and when a child would be referred
- extensive outreach by regional trusts, where specialist consultants work in a local trust. Day case surgery and outpatient sessions, conducted by regional trust staff alongside local consultants, would improve the confidence of local surgeons and anaesthetists and help maintain their skills²⁰
- ‘refresher’ rotations, giving local staff the opportunity to work in specialist regional trusts

Alternatively, the planned surgical service for young children could be shut and provided elsewhere in local or regional specialist trusts. Most hospitals do not operate in geographical isolation and a number of publications have pointed out that children’s surgery does not have to be provided at every hospital and trust.²³ However, this approach could have an effect on the children’s inpatient unit in a hospital and the ability of local surgeons and anaesthetists to provide emergency care.

To make these decisions, strategic health authorities and commissioners must work across an entire region to ensure that there is a network of safe, sustainable and planned services for children. A regional plan is needed to coordinate changes across local and regional trusts and to establish clinical networks of services for children.

Emergency care for children: life support and surgery

In a small number of hospitals, insufficient numbers of staff are trained to deliver resuscitation and initiate treatment in serious emergencies, especially at night. The level of training in paediatric life support skills also varies considerably across trusts.

Although few emergency cases require immediate surgical intervention, a number of trusts do not have a sufficient number of surgeons or anaesthetists working in children’s emergency care to maintain a full-time rota. Also, those on the emergency rota sometimes do not have sufficient experience to work with young children.

Life support in serious emergencies

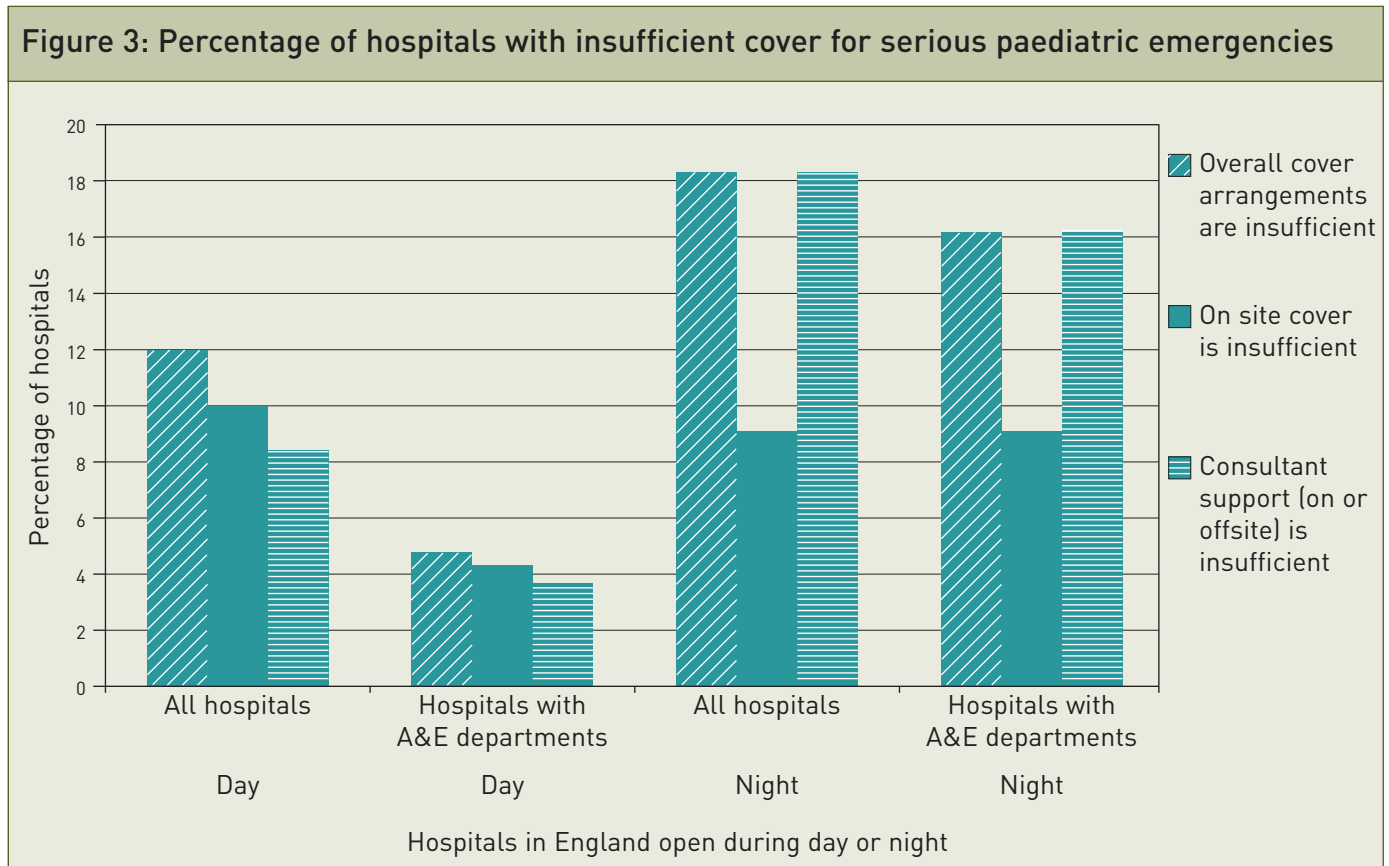
The hospital standard states that every acute hospital providing emergency care, inpatient care or surgery must secure and maintain a rota for the resuscitation of very sick children. Staff trained and experienced in advanced paediatric life support (APLS) or its equivalent (such as European paediatric life support or paediatric advanced life support) should lead the hospital resuscitation team. These staff should be able to recognise the symptoms of life-threatening illness, such as meningitis, asthma attacks unresponsive to normal medication, or head injury, and start emergency treatments to resuscitate and stabilise the child, including managing the child’s airway.¹⁶ At least one experienced member of staff is required on site.^{1,31} They should have back-up from a consultant who is either on site or within 20 minutes drive.

We asked trusts to tell us about the level of cover for paediatric emergencies at each of their hospitals at midday and midnight, including:

- staff with any professional background, such as emergency medicine, paediatrics, anaesthetics, intensive care or general practice
- staff at any level, such as nurses, senior house officers, specialist registrars (including non-career grades) and consultants
- the requirement was that they had been trained in advanced paediatric life support or the equivalent within the previous three years and were expected to cover the emergency rota

We are concerned that a small number of hospitals could not provide assurance that they had appropriate cover for serious paediatric emergencies. During the day, of the 248 hospitals that provided emergency, inpatient or day case care to children:

- 10% had insufficient on site cover for serious emergencies
- 12% had insufficient overall cover (including consultant support)
- ensuring on site cover by any staff trained in advanced paediatric life support was slightly more problematic than ensuring support from consultants (Figure 3)



During the night, of the 218 hospitals that provide A&E or inpatient care to children:

- 9% had insufficient on site cover for serious emergencies
- 18% had insufficient overall cover
- there were particular problems in providing back-up from consultants (Figure 3)

Hospitals with A&E departments are likely to encounter cases which carry the highest level of risk. When we considered only these hospitals, we found that 5% did not have sufficient cover for serious emergencies during the day, and 16% did not have sufficient cover at night* (Figure 3).

A report in 2003¹⁹ found that 24% of paediatric departments in England, Wales and Northern Ireland did not have sufficient cover for serious emergencies at all times. Our data included only England but it suggests that there has been some improvement. However, hospitals that still do not have sufficient cover need to urgently review their arrangements in light of the risk to patients. The Healthcare Commission is working with these trusts and their strategic health authorities to ensure that the appropriate cover is in place.

Staff training in life support for children

To provide continuous cover for life support, staff need appropriate training.

The hospital standard states that at every hospital location where care is provided to children there must be staff trained in basic life support for children. This training should be updated annually. Basic paediatric life

support techniques are now very similar to those for adults.³² Training can therefore be provided quickly and easily, for example, by a resuscitation adviser as part of an induction programme (a number of companies also provide short training courses at low cost).

The hospital standard also states that in A&E departments, surgical recovery areas, day case facilities, and on inpatient medical and surgical wards, there should be cover by staff who can provide advanced paediatric life support or its equivalent.

There has been a further range of professional and national recommendations relating to particular professions, for example:

- surgeons working with children should be trained in at least basic paediatric life support^{14, 15}
- emergency medicine, anaesthetic and paediatric specialist registrars and consultants should be trained in advanced paediatric life support (or equivalent) if they deal with acutely unwell children.¹⁵ This training has to be refreshed every three years¹⁶
- ideally all personnel dealing with children in a district general hospital should have life support training, such as advanced paediatric life support²⁰

There are areas of good practice in some trusts. However, the overall picture varied considerably. Figure 4 shows the variation in the proportion of nurses trained in basic paediatric life support in day case services. Figure 5 shows a similar picture for

*One hundred and eighty-seven hospitals in the review provided an A&E service during the day; 61 did not provide a full A&E service during the day but did provide inpatient or day case care. One hundred and eighty-seven hospitals provided an A&E service at night; 34 did not provide a full A&E service at night, but did provide inpatient care.

Figure 4: Percentage of nurses trained in basic paediatric life support (or paediatric life support) in day case services

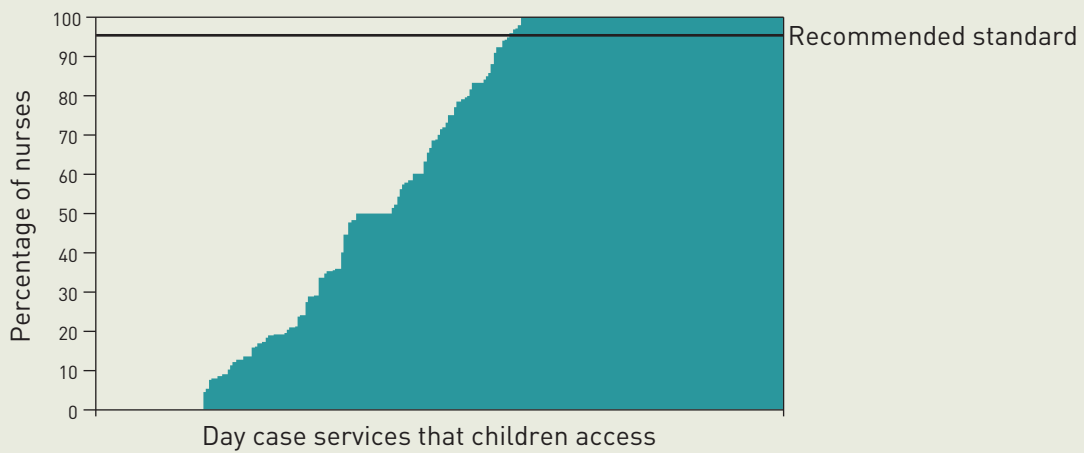
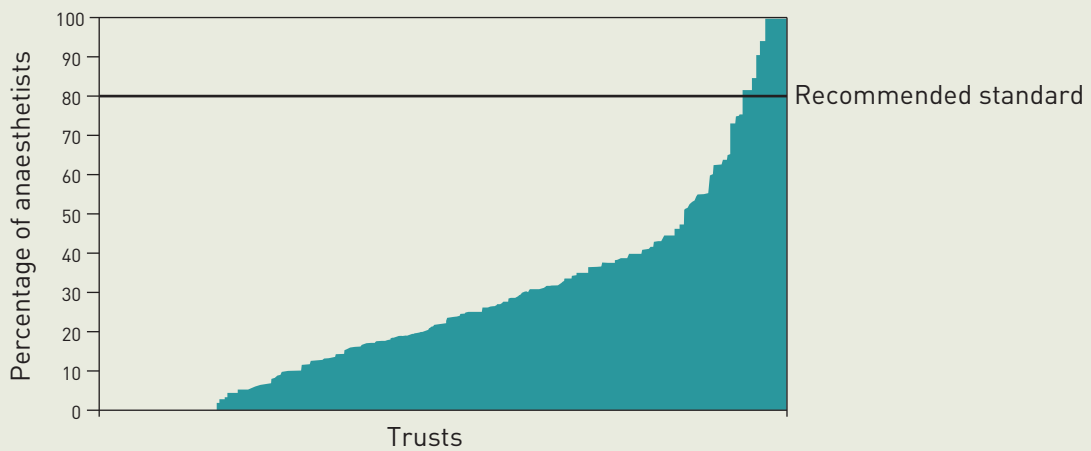


Figure 5: Percentage of all anaesthetists carrying out emergency work with children in a trust who have had training in advanced paediatric life support (or equivalent) within the last three years



anaesthetists trained in advanced paediatric life support. Other findings include:

- a large proportion (63% or 17,208) of the total registered nursing workforce that comes into contact with children was trained in basic paediatric life support
- 50% (545) of the individual services accessed by children did not have a sufficient percentage of nurses trained in basic life support ('sufficient' was judged to be 95% of registered nurses working in a service, as recommended by the Healthcare Commission's expert reference group)
- trusts report that between only 20% and 30% of surgeons received relevant training in basic or advanced paediatric life support (by speciality)
- in each one of the three major surgical specialities, more than 60% of trusts reported that none of their surgeons were trained in basic paediatric life support (Table 2)

- 58% of paediatricians (including consultants, specialist registrars and nurse consultants) had up-to-date training in advanced paediatric life support (or equivalent)
- only 31% of anaesthetists (29% of consultants and 32% of specialist registrars) declared to be working with children had up-to-date training in advanced paediatric life support
- 8% of trusts reported that there were no consultant anaesthetists with up-to-date training in advanced paediatric life support

This is an area of high risk for trusts. Trusts should use the feedback from this review to identify which staff need training in these important skills. One of the major challenges when children are accessing a large number of services in a hospital is identifying which staff work with children and making sure that they are trained appropriately. Reducing the number of surgeons and anaesthetists working with children, as discussed earlier in this report, will allow training needs to be more easily met. Ensuring that children access services designed specifically for them also helps to reduce the number of staff requiring training (see page 38).

Surgical speciality	Percentage of surgeons who work with children, that are trained in basic paediatric life support	Percentage of trusts with no surgeons trained in basic paediatric life support or paediatric life support
General surgery	27%	64%
Orthopaedics	25%	61%
Ear, nose and throat	20%	68%

Hospitals in which few children attend emergency departments

All (16) of the urgent care centres, such as minor injuries units or walk-in centres, and 3% (6) of the A&E departments taking part in this review see fewer than 5,000 children every year. This means that staff working in these facilities may not have sufficient exposure to children to maintain their skills in life support and emergency diagnosis.

Even A&E departments or urgent care facilities that are not supposed to be open to children need to be prepared and able to treat serious cases. This is because children are often brought to hospital by their parents.¹⁵ Trusts managing facilities in this situation must ensure that, if the hospital continues to provide open access emergency care, staff have exposure to a sufficient number of

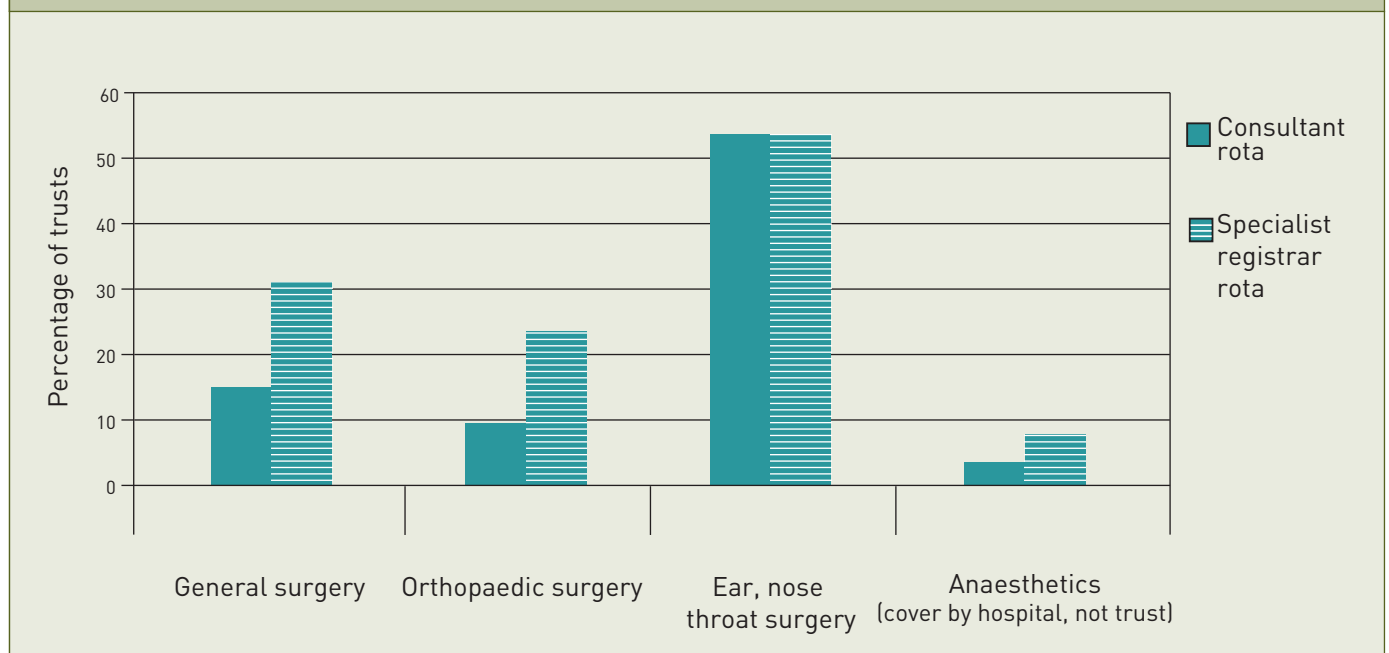
emergency cases involving children, for example, by rotation into other hospitals and through practice (see 'emergency care networks').

Emergency surgery

Trauma and minor surgical problems account for 85% of childhood attendance at A&E departments,¹⁴ although few of these emergencies require immediate surgical treatment. However, some trusts did not provide 24-hour cover for surgery and some staff carrying out emergency surgery may not have had appropriate experience to work with young children.

Figure 6 shows the percentage of trusts with an insufficient number of staff to cover emergencies involving children.

Figure 6: Percentage of trusts with insufficient staff to cover children's surgical emergencies 24-hours a day, seven days a week



At a considerable number of trusts, there were not enough surgeons to provide one full time 24-hour rota per speciality for the entire trust.* At a small number of trusts, there were not enough anaesthetists working with children to provide a full time 24-hour rota for each hospital.** Some reports have suggested that this situation is likely to worsen with progressive implementation of the European working time directives.³³

There were also concerns that some staff covering emergency rotas may not carry out enough work with children to be considered competent to work with younger children. The report by the NCEPOD in 1999¹⁸ found that some consultants worked with children in emergency situations very rarely. Our results also showed that, in a large number of trusts, consultants in general surgery and anaesthesia who did not carry out any planned work on children were being placed on emergency rotas covering children. This was the case in 55% (77) of trusts providing emergency general surgery and 14% (21) of those providing emergency anaesthesia. The level of exposure to cases involving children for these consultants would be limited to infrequent emergency cases. This does not represent a risk if the children presenting are older and have common or minor conditions. However, trusts need to be sure that this is the case.

Trusts without continuous surgical cover, or where staff have limited exposure to children, should have a number of arrangements to ensure that children receive safe emergency care. For example:

- night time surgery may be limited to children over a certain age or with minor or common conditions
- less urgent cases may be managed medically overnight, until appropriate surgeons arrive
- very urgent cases may be stabilised overnight and then transferred to another hospital for surgical treatment

Networks for emergency care

A number of the findings from the review have called into question the sustainability of emergency services in some trusts. For example, we have found that:

- continuous cover for life support was inadequate in a small number of trusts
- at a small number of A&E departments, small numbers of children were attending
- a considerable number of trusts did not have full 24-hour cover for surgery
- a number of trusts covered general surgery and anaesthetics rotas with staff who should only work with older children or those with common or minor conditions

Not all hospitals have to provide emergency surgical care for children of all ages 24 hours a day.²³ This service could be withdrawn at certain hospitals or at particular times (for example, withdrawn for young children overnight). However, this would require a greater level of skills to diagnose surgical problems in A&E, manage these children medically (for example, using advanced life support techniques) and transfer them to

*Insufficient staff to cover a rota was defined as fewer than five consultants, or fewer than four specialist registrars per trust.

**Insufficient anaesthetist staff to cover a rota was defined as fewer than five consultants, or fewer than four specialist registrars for each hospital providing emergency or inpatient care.

other local or regional hospitals safely if necessary. Pathways and protocols would have to be agreed between local and regional trusts, including the ambulance trust, resulting in a network of care. Likewise, not all hospitals have to provide an A&E department: emergency care could be provided through an agreed network of other local and regional trusts.*

If strategic health authorities and commissioners decide to keep an unsustainable emergency service open – for example, if the hospital is geographically isolated – they need to ensure that there is a network of emergency care services in place, including ongoing support for staff.

This should include:

- refresher training
- rotations so that staff get experience of planned and emergency care for children at regional trusts
- regular scenario practice for different emergency conditions
- audit to ensure individual surgeons and anaesthetists are working within their areas of competence

These arrangements are particularly important if inpatient care is not provided to children at the hospital. Without an inpatient unit, there are likely to be fewer paediatric emergencies, which will mean that staff will have less exposure to cases involving children. There will also be no paediatric staff to support the A&E department.

In the same manner as for planned care, strategic health authorities and commissioners must work across a whole region to ensure there is a network of safe and sustainable emergency services.

Inpatient care for children

A hospital will admit children to inpatient beds if they need either planned or emergency care.

We found that some paediatric inpatient units carried out less work with children than the minimum professional recommended level. This reflects the findings relating to planned surgery and emergency care and surgery, already highlighted in this report.

The Royal College of Paediatrics and Child Health³⁴ identified a number of fundamental issues that affect a trust's ability to provide a high quality paediatric service. In particular, it recommended that:

- small paediatric units admitting fewer than 1,800 children each year should not continue to exist unless they are geographically isolated
- small paediatric units less than 30 minutes by road from another paediatric unit should amalgamate into a single site and offer 24-hour facilities for inpatients

Twenty-nine (16%) hospitals providing inpatient care to children reported fewer than 1,800 admissions a year. The majority (21) were district hospitals, which provide general acute care. Three were specialist hospitals that are part of a broader, general acute trust,

*Limiting an A&E department to provide care for adults is not likely to reduce risk greatly because parents will still bring children to A&E of their own accord.

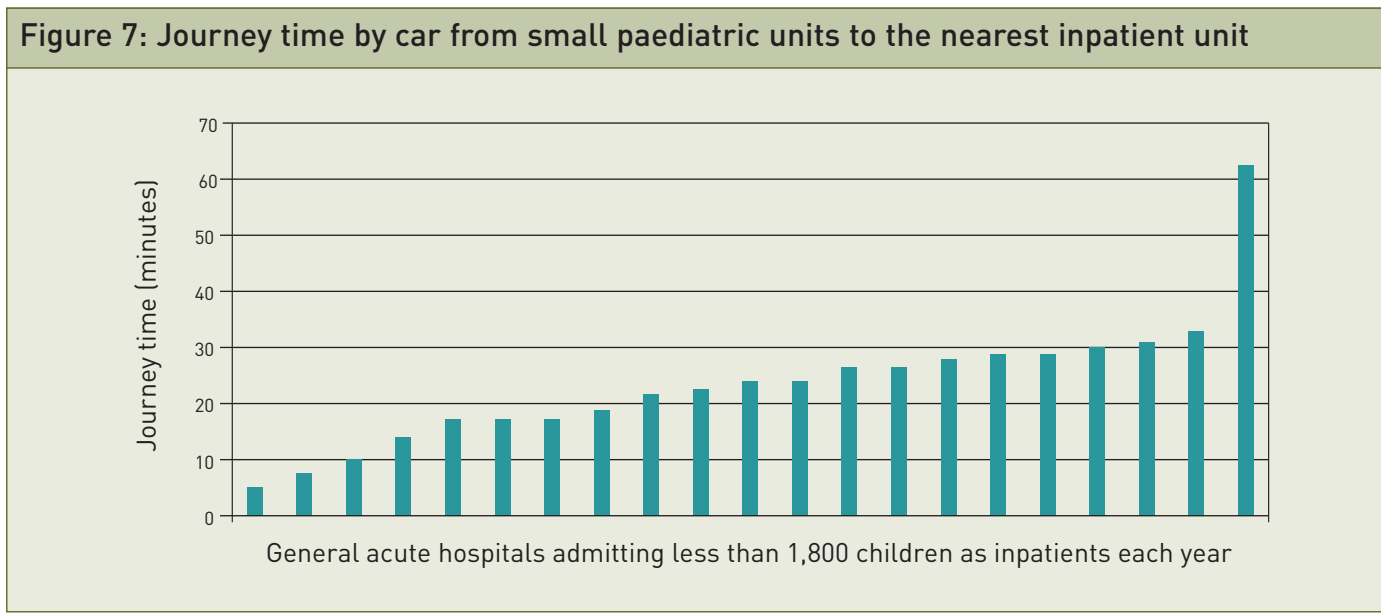
and five were single-specialty trusts operating out of one hospital. Seventeen of the 21 district hospitals are less than 30 minutes by car (not ambulance) from another district hospital that provides inpatient care to children (Figure 7).

Local strategic health authorities and commissioners should review the location of inpatient care for children, along with planned surgery and emergency care, to ensure that local services are safe and sustainable. Of course, access for the local population should be taken into account, including information about car ownership and public transport links. Any service receiving less than the recommended number of children a year that is to remain open will need additional support from neighbouring and regional trusts.

Managing pain

Across all hospital services, a reasonable number of nurses had received relevant training in assessing and treating children’s pain. The treatment of pain in A&E departments has also improved in recent years. However, a large number of individual services, particularly those providing day case and outpatient care, did not have sufficient numbers of nurses trained to alleviate children’s pain.

Pain is unpleasant, delays recovery and adds to the upset caused by illness, injury and clinical procedures. There is evidence that children’s pain is inadequately dealt with in hospital. A survey of young patients carried out by the Healthcare Commission in 2004³⁵ found that, of the 61% of young patients who suffered pain during their hospital stay, 23% reported that they were in pain all or most of the time, 52% were in pain some of the time and 25% occasionally.



There are two challenges in ensuring that children are in little pain as possible:

- many children are not as able as adults to communicate their pain, which leads to it being under-estimated
- research has found that some staff are reluctant to prescribe pain relief at all or use doses that are too small to address the child's pain adequately. This is because many drugs are not licensed for use with children and lack appropriate advice on dosage for children. However, the publication in September 2005 of the British National Formulary for children³⁶ should improve this situation

There have been improvements in the management of pain in A&E departments in recent years. A survey in 2004 showed that a greater number of A&E departments now assess children's pain formally upon arrival.³⁷ An audit by the Healthcare Commission and the British Association of Emergency Medicine¹⁷ found that the average percentage of children receiving analgesia within 60 minutes of arrival in the A&E department increased from 60% in 2004 to 70% in early 2005.*

Training nurses in the management of pain

Training is crucial to the effective management of pain in children. The Healthcare Commission's reference group recommended that 50% of nurses in services

in which children are seen should be trained to assess children's pain. In addition, in each location, there should be at least one nurse per shift trained to administer 'first-line' pain relief (such as ibuprofen and paracetamol) according to agreed protocols.** This means that, once an assessment of pain has been completed, pain relief can be given, without waiting for a medical authorisation.

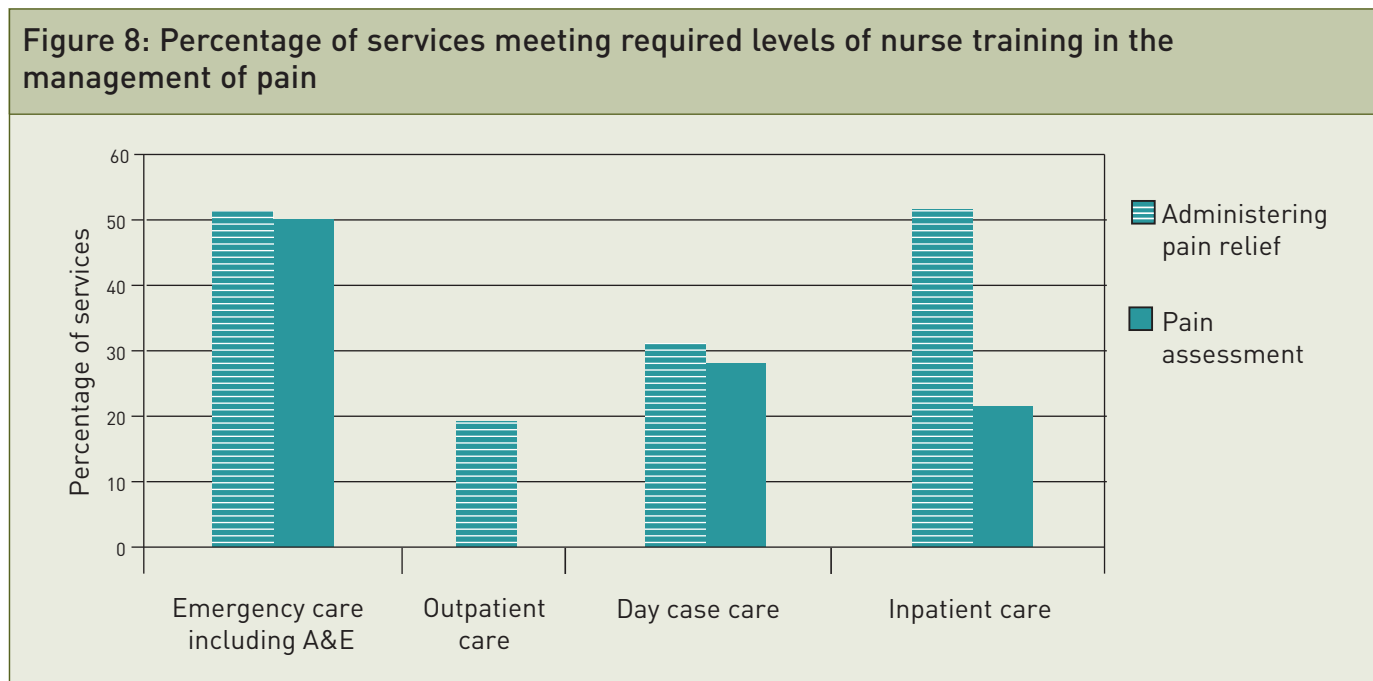
Overall, 43% of nurses working with children had received relevant training in the assessment of pain in children, and 27% had received the relevant training in the administration of pain relief. The majority of individual services that children use did not meet the recommended standard of 50% of trained nurses. A&E departments have the highest numbers of trained nurses, possibly reflecting the effort made to improve the management of children's pain in this area in recent years. However, in day case care, where a large number of children receive surgery every year, levels of training in the assessment and treatment of pain were poor (Figure 8).

Pain teams

Pain teams are multidisciplinary teams of professionals such as pharmacists, anaesthetists and nurses. They specialise in the control of pain and provide advice on the management of pain to other staff in the hospital.

*The British Association of Emergency Medicine has established standards of treatment for a number of conditions for which patients, including children in pain, attend A&E departments. Children in moderate or severe pain as a result of a fractured arm or wrist were included in the audit and the proportion of children that had received pain relief within 20, 30 and 60 minutes of arrival was recorded. An improvement was seen in trusts that responded to the original audit and the re-audit.

**In A&E, inpatient and day case care, there should be at least one trained nurse per shift.



The majority of hospital facilities used by children were covered by pain teams, but not by paediatric pain teams with particular expertise in the management of children’s pain. Provision of specialist paediatric advice was slightly better in inpatients’ wards (30%) than day case services (22%). If general pain teams are expected to work with children, they must be skilled to provide specific advice on children’s pain.²⁵

Meeting the broader needs of the child

The clinical outcome of surgical and medical treatment is extremely important. However, children in hospital have broader needs. More than most other groups of patients, they need to be kept safe, they should be active partners in decisions, and they have a basic need for play which can also help their understanding and speed their recovery.

This review found that progress in this area was generally poor: the broader needs of children were not being recognised or given proper priority in many trusts. Safeguarding children remains a major area of risk and many children are having worse experiences of hospital than they should because of a lack of communication training and staff who specialise in play.

Safeguarding children

The term ‘safeguarding children’ means protecting children from maltreatment, preventing the impairment of children’s health or development, and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.³⁸

The results of this review raise important concerns about the protection of children from intended harm and neglect. Levels of basic training in child protection were often not up

to standard, and there were particular problems relating to the levels of intermediate training in emergency care and inpatients' departments. There was a significant and unexplained variation in the delivery of child protection training across trusts.

All healthcare organisations have a statutory responsibility to make arrangements to safeguard and promote the welfare of children: this is also the responsibility of all staff working with children. *Working Together to Safeguard Children*³⁸ states that all staff working with children should attend training in safeguarding and promoting the welfare of children, and have regular refresher training. It states that employers have a responsibility to ensure that all staff, including administrative staff, temporary staff and volunteers who work with children, are made aware of the arrangements for safeguarding children and their own responsibilities in this area, and have the opportunity to attend local courses. The hospital standard states that trusts need to make sure that staff at all levels are aware of their corporate and individual responsibility to safeguard children and that staff working with children are trained, updated, supported and supervised appropriately. This is a major risk area for trusts.

Child protection skills are particularly important for staff in A&E departments because so many children attend these services with unexpected or accidental illness or injury, and many are treated very quickly before being discharged. *A Team Response*¹⁶ states that the emergency team should always include practitioners with the skills to recognise and be able to respond to concerns about the protection of a child.

Basic child protection training (level one)

Level one training is very basic, simple training that all staff, including those who have no regular contact with children, such as administration staff, should receive. It should be updated annually and, where possible, included as part of the induction of new staff. It covers information on who to contact with concerns about the welfare or treatment of a child.

Across all services in which children are seen, 60% (16,324) of nurses had up-to-date training in basic child protection. Ideally, 95% of nurses in any one service should be trained. However, 58% (632) of services nationally did not meet this standard. No one type of service was better than another: around 60% of inpatient, day case, outpatient and emergency care services did not meet the required standard.

Overall, trusts reported poor levels of training in basic child protection among surgeons and anaesthetists working with children. Some trusts did not hold training records and so were unable to provide assurances that staff had been trained. For example:

- 23% of general surgeons working with children were trained in basic child protection and 62% of trusts reported that none of their general surgeons were trained in basic child protection
- 30% of orthopaedic surgeons working with children were trained and 53% of trusts reported that none of their orthopaedic surgeons were trained
- 25% of ear, nose and throat surgeons working with children were trained and 58% of trusts reported that none of their ear, nose and throat surgeons were trained

- 21% of anaesthetists working with children were trained and 46% of trusts reported that none of their anaesthetists were trained

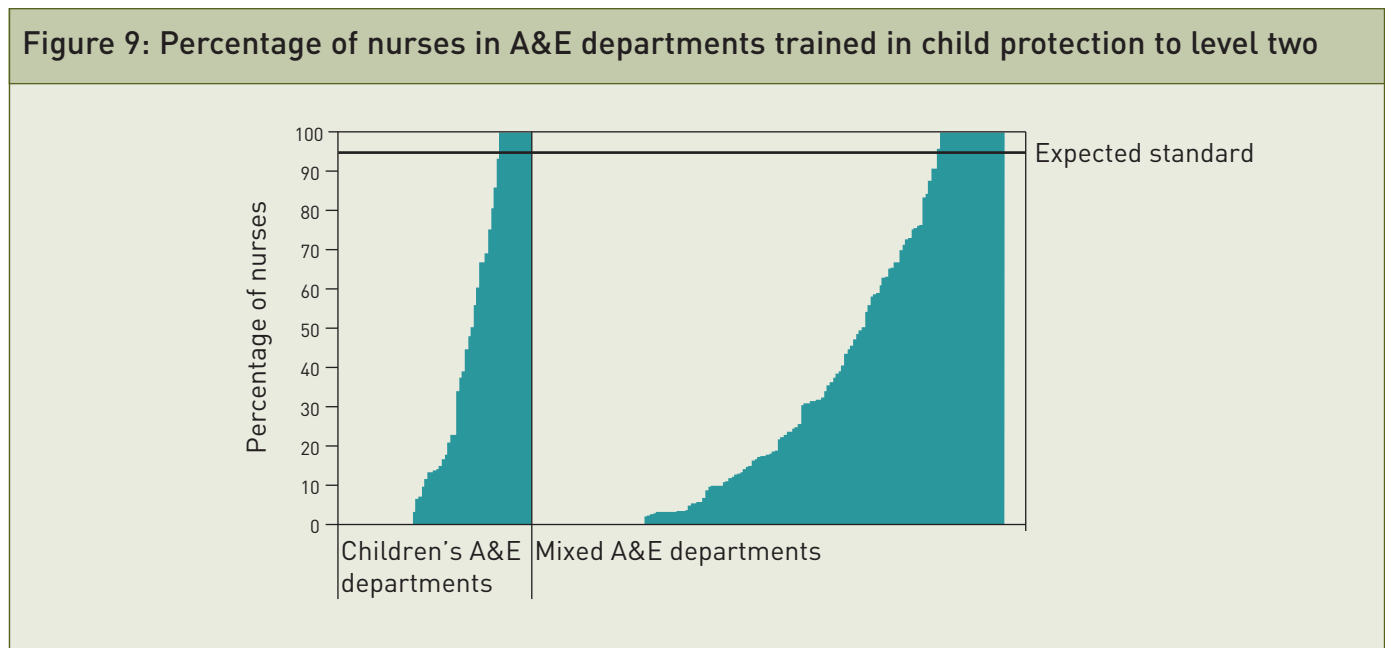
Levels of training varied significantly among trusts. For example, 21 trusts reported that all their general surgeons were trained in basic child protection.

Intermediate child protection training for those who often work with children (level two)

A certain number of staff in all services used by children, as well as all staff who spend a considerable amount of their time working with children, should be trained to level two. This training enables staff to recognise the signs and symptoms of abuse. It is particularly important that staff who work within services, such as nurses, are well trained so that they can draw the attention of designated child protection staff to any cases of concern.

Our findings show that, across all services in which children are seen, 37% (10,179) of nurses had received level two training in child protection. Ideally, 95% of nurses in inpatient and A&E departments and one nurse on each shift in day case and outpatient care should be trained in child protection to level two. However, 70% (769) of services did not meet this standard. There were particular concerns in A&E, given the nature of the work, where 85% of departments were not up to standard. Again, there was significant and unexplained variation across hospitals in this area (Figure 9).

The level of training among paediatric staff, who usually lead on child protection issues, was good: 71% of paediatricians (consultants, specialist registrars and nurse consultants) had received relevant training in child protection to level two or above.



Given the findings of the inquiry into the death of Victoria Climbié,¹¹ published in 2003, we are very concerned about the continued poor level of training in child protection in services. Trusts must take action to assure themselves and the populations they serve that staff in all services are suitably trained to raise concerns about a child. All staff should receive basic training in child protection. Trusts also need to deliver intermediate training to staff where necessary. Identifying the surgeons and anaesthetists who should work with children (as discussed earlier) and treating children within particular focused services for children (as opposed to within a range of services across the hospital) will reduce the number of staff who need this training. This issue is covered in more detail later in this report.

Communication and choice

The level of training in communication with children is poor, especially in outpatients' departments and among surgical and anaesthetist staff.

Effective communication between health professionals and children is extremely important. If children understand their treatment, they will be less scared and more able to cope. If professionals are trained to understand the way children, even those unable to talk, communicate, they will be able to provide better treatment, including more appropriate pain relief. Being able to communicate effectively with children also helps staff to fulfil their responsibilities for safeguarding children. The *United Nations Convention for the Rights of the Child*⁹⁹ states that children have a right to be involved in decisions about their care: they need to be

given information in a way they can understand, along with suitable choices, which will vary according to their stage of development.

In the Healthcare Commission's survey of young patients,³⁵ 47% of respondents said they were not involved in decisions as much as they wanted during their stay in hospital. Only 57% of young patients aged over 12 reported that doctors gave them information about their care and treatment in a way they could understand (very few patients aged below 12 responded for themselves to this question).

The hospital standard states that staff working with children and young people should be trained to:

- communicate with children and young people at various stages of development
- provide information that is factual, objective and non-directive
- give bad news in a sensitive, unhurried fashion
- enable children and their families to exercise choice, taking account of age and competence to understand the implications
- understand the concept of competence in giving consent

We asked trusts whether their staff had received formal training in communicating with children as part of their induction or ongoing (in house or external) training. They should have been taught how to discuss procedures, obtain consent (where relevant), provide choice and detect fear or pain. We included communication training received, for example, as part of a child protection course or training in handling bereavement. However,

in spite of this broad definition of communication training, few trusts reported that staff had received any training in communicating with children.

Nurses have ongoing contact with children in most services. However, only 24% of nurses who come into contact with children had received formal training in communication. The situation was best in inpatients' departments (30%) but worst in outpatients' departments (11%).

Training among surgeons and anaesthetists was very poor. Surgeons have a duty to explain procedures and, where appropriate, gain consent. However, only very low proportions of staff working with children had received training in communication:

- 9% of general surgeons
- 7% of orthopaedic surgeons
- 8% of ear, nose and throat surgeons
- 9% of anaesthetists

There are few recognised external courses in communication with children, and most staff have presumably learned skills through daily experience, or may have had some training as part of their professional pre-registration training. However, the lack of information available on whether staff have received relevant training is of concern.

As effective communication greatly affects the experiences of children and parents, trusts should prioritise this area more highly. They need to assure themselves that the skills of staff are up-to-date and appropriate. They should facilitate learning through scenario practice, observation and training, and they

should collect records of training for the purposes of assurance.

Play

In some hospitals (including district general hospitals), children had very good access to trained staff who specialised in play and structured play. However, in some other hospitals, there were no staff who specialised in play at all.

Children visiting or staying in hospital have a basic need for play. Play may also be used as a therapy or distraction, and is a powerful means of communication. It is a way of helping the child to understand and prepare for what is happening, adjust to a potentially frightening environment, and exercise choice. There is evidence that play speeds recovery and reduces the need for children to receive general anaesthetic while receiving certain forms of treatment.⁴⁰

In 1991, the Department of Health recommended that all children staying in hospital should have daily access to a person who specialises in play.⁴¹ The hospital standard also states that play and recreation needs should be met routinely in all hospital departments providing a service to children, including day care facilities and A&E departments. The suggested arrangement is that play specialists take a lead in modelling techniques that other staff can adopt.

Fourteen per cent (31) of hospitals providing inpatient or day case care to children did not have any staff who specialised in play. Our results show that, in hospitals where there were staff who specialised in play, there was significant and unexplained variation in the

number of staff available (Figure 10). These hospitals* provided between five and 152 minutes of play time per child in inpatient or day case care.

The Intercollegiate Committee for Services for Children in Emergency Departments says that A&E departments treating more than 16,000 children a year should have a play specialist to cover peak times, including weekends.¹⁵ Of the A&E departments in the review, 28% had play specialists, as do 32% of all A&E and urgent care facilities.

As staff who specialise in play do not deliver clinical care, they may not be seen as a priority in some trusts. However, their work directly with children or through other staff can greatly improve the experiences of children in hospital. Trusts need to recognise

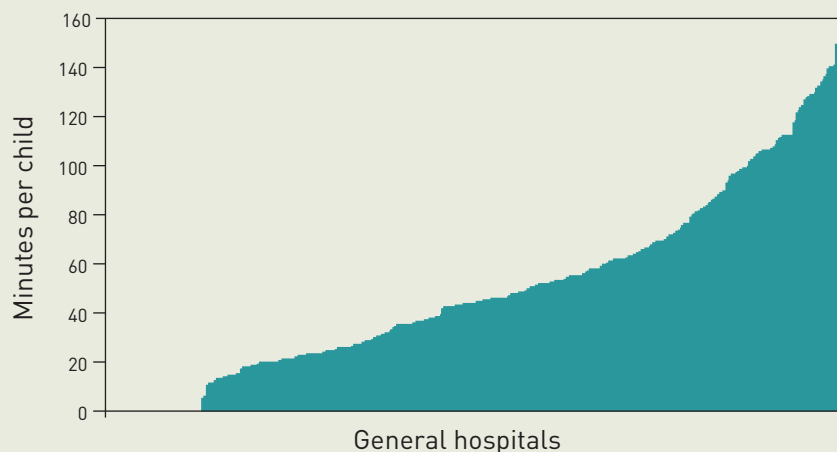
the impact this has and give it a much higher priority.

Child-friendly and child-only environments

The hospital standard states that the care of children and young people in hospital should be provided in buildings that are accessible, safe, suitable, and child- and family-friendly. It also states that children should be treated in separate facilities, away from adults, wherever possible.

We found that there has been progress in this regard. However, the good practice seen in some services needs to be reflected more widely. On balance, we found that the needs of children were better met when they were

Figure 10: Number of minutes spent with each child (inpatient or day case) during their entire hospital stay, by staff who specialise in play*



*Assumes that staff who specialise in play cover only children in day case and inpatient care and that 80% of their time (excluding annual, sickness and study leave) is spent in direct contact with patients.

*Excluding trusts providing paediatric intensive care or specialist children's care, where children spend longer in hospital.

cared for in child-only services, usually managed by the paediatric directorate.

Child-friendly environments

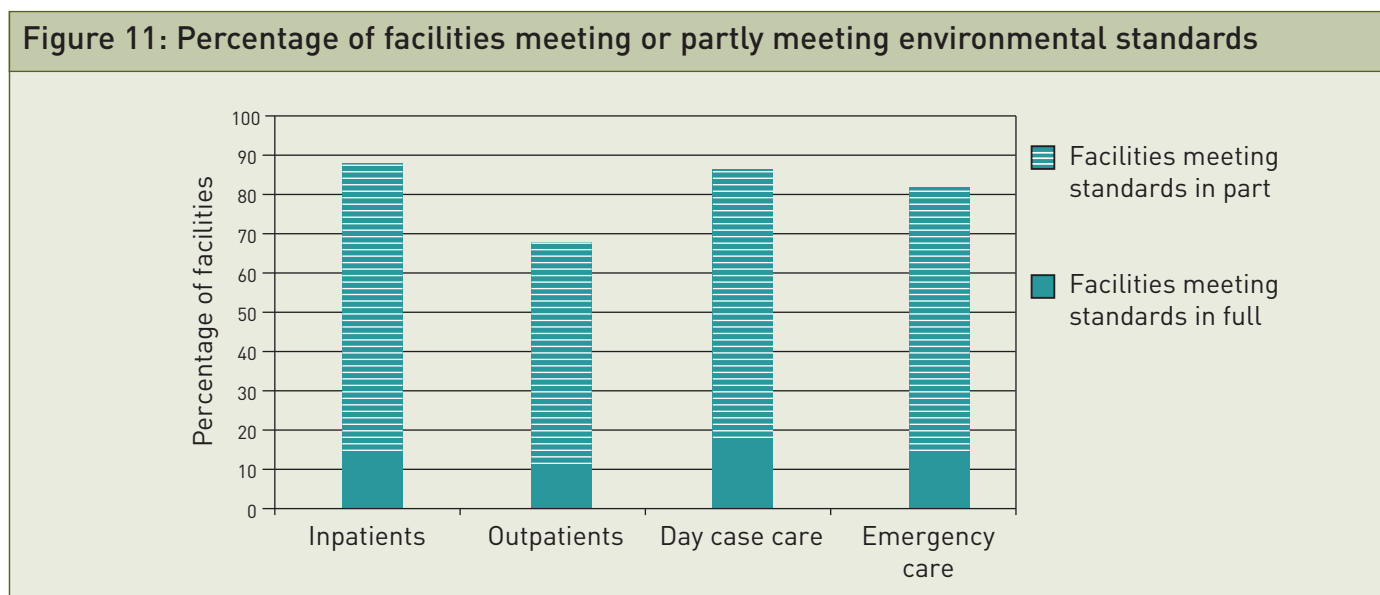
A good proportion of facilities used by children were going some way towards meeting standards, but few were meeting them in full.

*Improving the patient experience*⁴² states that “studies clearly show that the design of spaces, together with sensitive lighting, colour, sound attenuation, texture and material specification are essential to the child’s immediate wellbeing, healing process and ultimate outcome”. This was published along with a *Health Building Note*⁴³ to complement the hospital standard. These documents guide all future builds or refurbishments of facilities for the care of children in hospital, and highlight the need, for example, for visually stimulating environments, appropriate security, low reception desks and play areas. These documents promote a degree of physical

separation between children and adults in A&E departments (particularly in waiting and treatment areas), surgery recovery areas and outpatients’ clinics, as well as wards, so that children are not exposed to potentially frightening behaviour and, equally, so that adults who are unwell are not disturbed by noisy children.

Seventy-nine per cent (1,158) of the facilities we reviewed met or partly met the Health Building Note’s environmental requirements. However, of these, only 14% (200) met the requirements in full. Inpatient and day care facilities were the most likely to meet environmental standards (Figure 11).

Outpatients’ departments had the greatest room for improvement. Many trusts provided outpatient services in a large number of locations (542 in total), particularly when compared with inpatient (264), day (307) or emergency care (352). Our findings show that the more outpatient facilities used by a trust, the less likely it was to meet environmental requirements at each of these locations.



Trusts were making encouraging improvements to the environment in which care is provided, but all facilities used by children need to meet standards fully. Treating children in a smaller number of facilities will help to achieve this objective. However, some trusts may not be able to reduce the number of locations in which services are provided because this would greatly increase travelling times. In these instances, there are a number of practical measures that should be put in place to improve the experiences of children. For example, in outpatients' departments, trusts could install water coolers, ensure that there are partitioned waiting areas for children, and organise appointments so that all children are seen at the start of a clinic, separately from adults.

Child-only services

Trusts were caring for a very high proportion of children in child-only wards. But this achievement did not extend to other services, particularly A&E departments, outpatients' departments or inpatient facilities for young people. The proportion of children cared for in child-only services varied considerably across all trusts and some trusts with child-only facilities could make far better use of them.

*Improving the patient experience*⁴² states that, wherever possible, children should be treated in separate dedicated facilities. Our review asked how many children used child-only services, including:

- child-only A&E or emergency short-term assessment services - separate from general A&E with children's waiting areas and treatment areas

- child-only planned day case services (treating medical and/or surgical cases) - with segregated wards or bays separate from adults
- child-only outpatient departments - a separate children's department with separate child-only waiting and treatment areas and child-only clinics
- beds for children and young people - segregated wards or bays separate from adults

The majority (99%) of children receiving inpatient care were treated in child-only wards. Day case care also performed relatively well in this regard (79%). However, there was room for improvement in emergency care (38%) and outpatients' departments (46%) (Figure 12). There was also an unexplained level of variation across hospitals in A&E, outpatients and day case care (Table 3).

One of the arguments often made against the establishment of child-only services is that the number of children attending services is not sufficient to justify the investment. However, our evidence does not necessarily support this. Some hospitals, including those which treat a small number of children in A&E, had child-only emergency services. Others, including those which treat large numbers of children, had not chosen to invest in this area (Table 4).

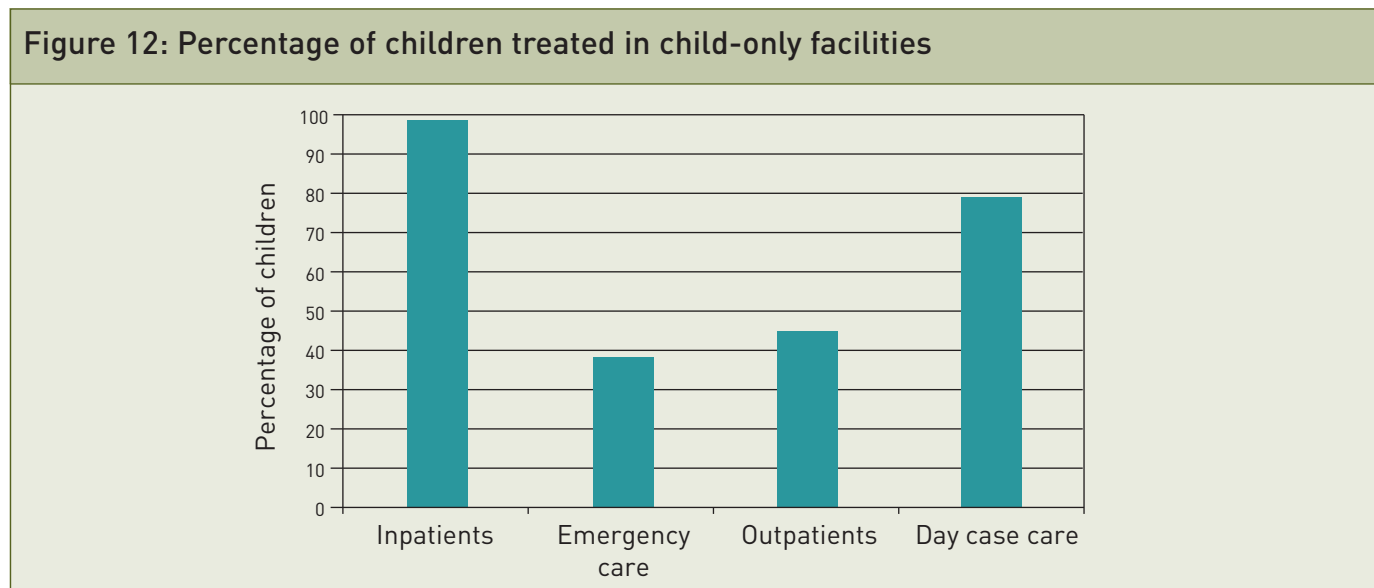


Table 3: Number of hospitals at which all children access child-only care, or no children access child-only care

Type of care	Number of hospitals providing this type of care	Of which, where all children access child-only care	Of which, where no children access child-only care
A&E departments	190	33 (17%)	63 (33%)
Outpatients' departments	371	168 (45%)	56 (15%)
Day case care	222	42 (19%)	120 (54%)

Table 4: Total number of children accessing A&E, and the percentage of those children that access child-only care, at different hospitals

Total number of children accessing A&E each year	Percentage of children accessing child-only A&E			
	96-100% excellent	51-95%	6-50%	0-5% poor
>25,000	11 hospitals	2 hospitals	2 hospitals	2 hospitals
15,001 - 25,000	21 hospitals	2 hospitals	3 hospitals	31 hospitals
5,001 - 15,001	8 hospitals	4 hospitals	0 hospitals	92 hospitals
1-5,000	8 hospitals	0 hospitals	0 hospitals	14 hospitals

Making better use of existing child-only facilities

Many hospitals already had an outpatient department for children. This was often not fully used because clinics were arranged according to surgical or medical speciality (for example, ear, nose and throat, or dermatology) and included adults. They were not arranged around children as a group of patients. At 70% of hospitals with an outpatient department for children, less than 95% of children attended the department. Many hospitals could move more outpatients clinics into children's departments (Table 5). This has been a criticism over a number of years.^{14, 42}

Where this is not possible because of the need for specialist equipment, for example at fracture clinics, children should at least be grouped together at the start or end of a clinic and appropriate nursing cover should be provided.

Existing children's A&E departments could also be used more effectively by some hospitals (Table 5). Trusts need to identify the most common times of day children arrive for emergency care and ensure that the department is open to receive most of them. If staff in general A&E and children's A&E departments can provide cover for each other, there would be added flexibility and trusts would be able to keep children's A&E departments open for longer.

Services for young people

The hospital standard states that "children should be cared for ... on wards that are appropriate for their age and stage of development". Hospitals are very good at ensuring younger children get access to children's wards. However, the distinct needs of young people (adolescents) are often not met.

A report in 1990⁴⁴ found that "in an appropriate environment and with care designed specifically for them, adolescents will recover quicker, particularly when their emotional, educational and social needs are understood". Young people usually prefer to be located alongside people of their own age, which makes it easier for suitable entertainment, education and privacy to be provided. Adult wards are not equipped to meet these needs and they do not allow trusts to fulfil their duty to safeguard children, which continues until a young person is 19 years old.

A survey in 2001⁴⁵ found that an average district general hospital has sufficient attendances to support a ward for young people of between 12 and 15 beds. The choice offered to young people, however, is often of either a child's or an adult's bed: the Healthcare Commission's survey of young patients³⁵ found that, of the young patients who would have preferred to be on a ward for adolescents, 58% were actually placed on a ward for children and 16% on a ward for adults.

Type of care	Number of hospitals with children's A&E or outpatients' department	Of which, number at which less than 95% of children are seen in children's facilities	Proportion of children seen in children's facilities at these hospitals
A&E departments	49	14 (29%)	47% - 91%
Outpatients' departments	203	142 (70%)	8% - 94%

Nationally, the number of beds provided for young people was poor. Eighty-four per cent (144) of hospitals did not have separate beds for young people. Of those patients aged between 13 and 18 (more than 21,000 inpatients each year), only 7% were treated in units or separate bays for young people.

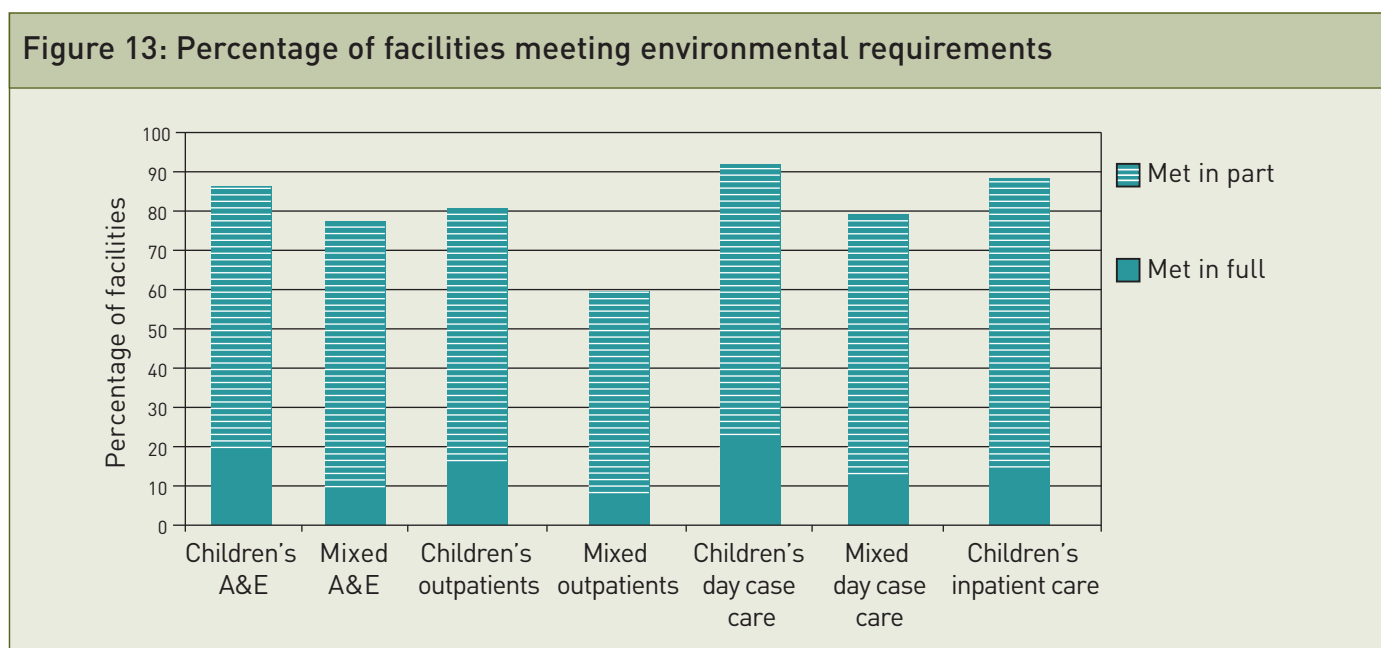
Achieving the hospital standard

Nationally, child-only services were far more likely to meet the requirements of the hospital standard in terms of quality of care. Inpatients' services performed well in this review because the great majority of children have access to child-only wards, where staff are better trained and the environment is focused on children.

Child-only settings were at least twice as likely fully to meet environmental

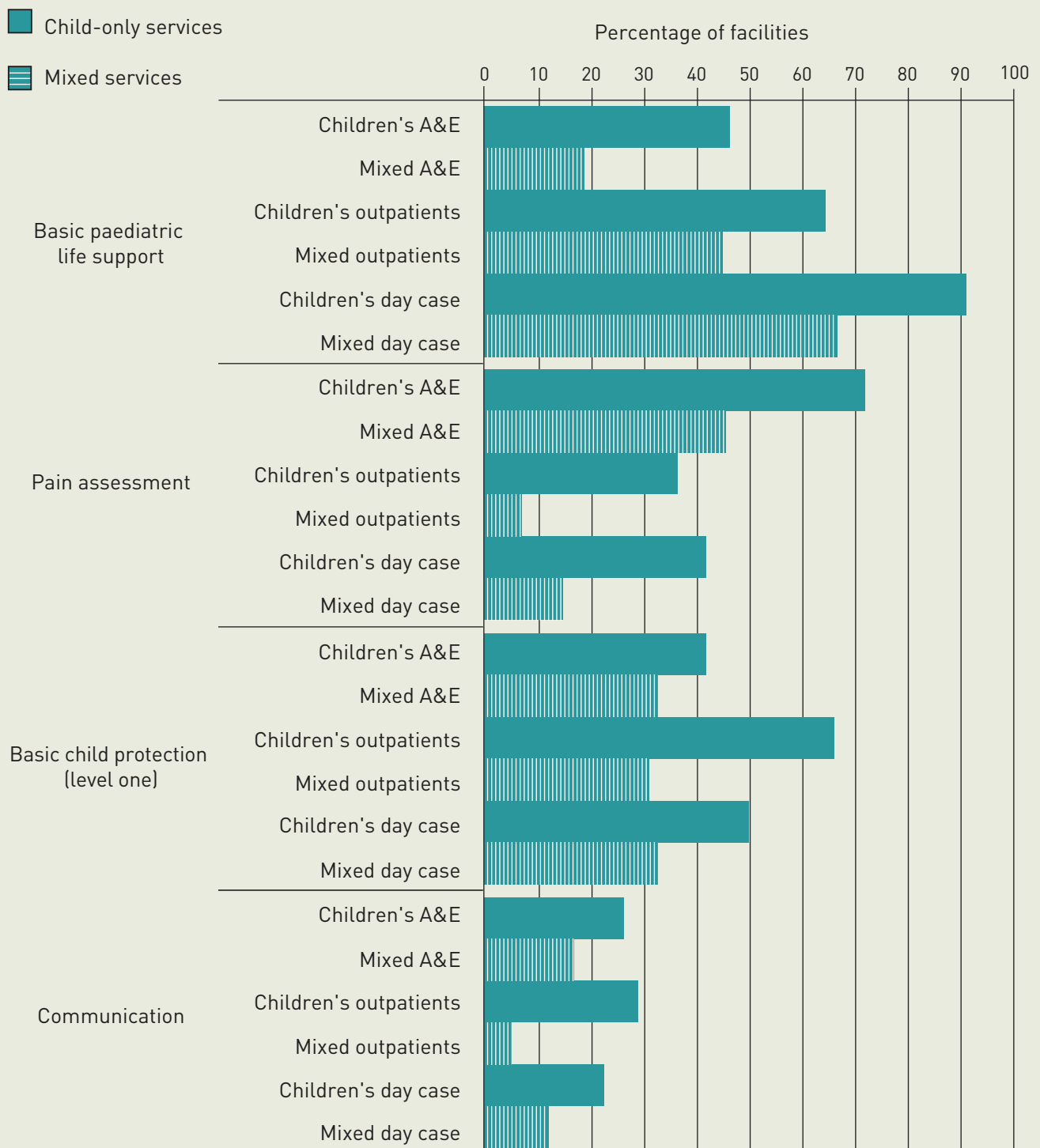
requirements such as separate areas for children, appropriate security and play facilities (Figure 13). Registered nurses working in child-only settings were more likely to be appropriately trained in paediatric life support, the assessment of pain, child protection and communication (Figure 14). And a registered children's nurse was nearly twice as likely to be present in child-only A&E departments and day case services, and nearly four times as likely to be present in child-only outpatients' departments and inpatients' services, compared with mixed settings for both adults and children.*

It is not surprising that child-only services benefit children significantly, in terms of physical environment and staffing. They give trusts the opportunity to focus on the needs of the child.



*Only occasions when mixed child-adult settings were caring for children were included for comparison.

Figure 14: Percentage of child-only or mixed facilities meeting the required standard for nurse training



In 2005, 1.8 million children used a mixed children's and adults' A&E department. More than 62,000 were treated at a mixed day case unit, nearly 10,000 were treated on an adult ward in a hospital, and there were 2.5 million attendances at mixed outpatients' departments. Compared to children accessing child-only services, this significant number of children received care of a lower quality.

To improve, some hospitals could make far better use of their existing child-only services (such as children's A&E or outpatients' departments). Others face the option of developing new child-only services or bringing all their mixed children's and adults' services up to the hospital standard. Implementing the hospital standard across mixed services may, depending on local circumstances, be harder than consolidating children's care into fewer areas within a hospital or creating a new child-only service. Trusts need to review all the locations at which care is provided to children in their hospitals and decide on the service model that will enable them to meet the hospital standard throughout.

Conclusions

This section of the report summarises key findings from the review, and introduces a discussion of three major themes that underlie the quality and sustainability of services: governance and performance management, leadership and planning. These themes were evident throughout the early part of the review, in feedback relating to the collection of data and during our work with the trusts most need of improvement.

Results of the improvement review

The review paints a mixed picture of services for children in hospital. Inpatients' services generally provided a good service for children. This was closely linked to the fact that the majority of children were treated in child-only wards where the environment and the staff were focused on their needs. There have been improvements in recent years, for example, in the management of pain in A&E departments. However, there were a number of areas where performance was poor or varied.

We found that appropriate arrangements were in place to ensure the quality and safety of clinical care at most trusts. However, there were considerable risks in a significant minority of trusts. There was insufficient cover for emergencies at some hospitals. Some individual staff and some paediatric units did not see enough children to maintain their skills. The management of pain was patchy.

Much improvement is needed to ensure proper safeguarding of children in most trusts. The broader needs of children (such as communication and play) were also generally not well met.

*Excluding specialist children's hospitals and trusts with paediatric intensive care units.

**Correlation coefficients with overall review performance: child-only services = 0.80; local services = 0.41; cover = 0.61; training = 0.62, maintaining skills = 0.50.

Progress has been made in improving environments and ensuring that children access child-only services. However, good practice needs to be more widely evident in different services across the hospital.

Child-only care: the overall success factor

In the review, the most important factor for success for local trusts* was the proportion of children treated in child-only services.

The better a trust performed in any one of five key review questions, the better its performance in the review as a whole. However, good performance in the first question - the extent to which children access child-only and child-friendly services - was the strongest indicator of good performance in the review** because it was strongly associated with good performance in all the other questions (except the question about local services). This means that, if more children access child-only services, they are more likely to benefit from appropriate levels of staff who have received relevant training and have had more opportunity to maintain their skills.

We therefore recommend that trusts reduce the number of locations in which children are treated in each hospital, ensure that children's work is focused and treat children within child-only services. Even if child-only services cannot be created, cutting the number of locations where children are seen and thereby concentrating children's care into fewer places will have an impact. Likewise, identifying and reducing the number of staff working with

children will direct training and help staff to maintain their skills in working with young children in both planned and emergency situations.

Governance and performance management

One of the main challenges for trusts participating in the review was identifying all of the services that they provide to children and all of the staff (for example, surgeons and anaesthetists) who work with children. For example, trusts found it hard to identify the range of outpatients' clinics (outside the outpatients' department for children) where children were seen.

Many trusts also did not have central training records, particularly for surgeons and anaesthetists. Where there were training records, they often did not log whether staff had received even basic training in working with children.

Being able to identify where children are treated across the hospital, who they are treated by, and whether these staff have received relevant training and are competent to work with children is extremely important: it is the first step towards ensuring that training needs are identified and that services come up to standard. Hospital trusts must make sure that they collect proper records in order to assure themselves and the populations they serve that they are meeting the hospital standard. They also need to include all services that are accessed by children, inside and outside paediatrics, within these performance management arrangements.

Leadership of children's services across the hospital

On balance, we found that the needs of children were better met when they are cared for in services managed by the paediatric directorate. Results show how child-only services (usually managed by the paediatric department) provided a higher quality service to children than mixed services (usually run by other directorates, such as surgery and emergency care). Inpatient settings performed well because the vast majority of children accessed child-only wards, operated by paediatrics.

Non-paediatric directorates face conflicting demands, since other priorities compete with provision for children. However, large numbers of children are treated by non-paediatric directorates (for example, four times as many children are treated in A&E departments as in inpatients' wards). Leaders of surgical and emergency care directorates must accept that they have to meet the hospital standard, and improving the provision of services for children must be integral to their plans. This report highlighted some improvements in A&E services in recent years (for example, in respect of the management of pain), which reflect such increased ownership.

The paediatric directorate has an important role to play in helping other directorates to raise standards, in terms of both leadership and practical support, such as providing nurses on rotation (for example, one session each week) to mixed outpatients' departments or day surgery units. It is worth noting that in those trusts that performed most poorly in the improvement review, leaders in paediatrics often focused too inwardly on the paediatric

department. The directorate needs to see itself as responsible for driving improvements in the care of children across the trust and all its services. Indeed, the Royal College of Paediatrics and Child Health sees this as part of the duties and responsibilities of paediatricians.⁴⁶

The hospital standard requires each trust to designate a member of the board to be responsible for children's services and to reinforce clinical governance for the care of children. It is explicit that these arrangements cover all parts of the hospital. Designated board members need to scrutinise all services accessed by children and influence all the directorates that contribute. They need to ensure that they manage the performance of all relevant services, in respect of the quality of care they provide to children. Evidence from trusts we visited and the results of the review seem to show that some boards are still not recognising care for children as a matter for the board and the trust as a whole. Greater scrutiny of services across the trust is needed, accompanied by better reporting of progress to boards, with a particular emphasis on services provided to children outside the paediatric department.

Regional networks and forward planning

Some of the findings in this report have called into question the sustainability of particular local services. Some trusts and services simply do not treat enough children for staff to maintain their skills. Thus, there is a choice to be made (dependent on local geography and characteristics of the local population). Either local refresher training, rotations into regional trusts and outreach from regional trusts must be increased, so that local skills (particularly working with young children) can be maintained. Alternatively, certain services should be closed (or only provided during the day or to older children) and improvements made to local A&E departments and retrieval and transport services, so that emergencies can be managed safely or transferred promptly to other local or regional trusts.

To do this, strategic health authorities and commissioners must work across a whole region to ensure there is a network of safe, sustainable services. A regional plan for both emergency and planned care is needed to coordinate changes across local and regional trusts and establish clinical networks for children's services.

Recommendations

Recommendations for hospital trusts

Boards must assure themselves and their local population that they are making progress on the hospital standard. They need to be sure that the services they provide to children:

- are of high quality and clinically safe, with suitable levels of staff who are appropriately trained and can maintain their skills in surgery, life support and the management of pain
- meet the requirements for effective safeguarding
- address the broader needs of children for communication and play
- are delivered in child-only or child-focused environments

Trusts should check that standards are being met in all mixed child and adult services as well as child-only services.

If they have not done so already, boards can compare their performance with that of other trusts and identify areas for improvement. The individual results for each trust are available on the Healthcare Commission's website at www.healthcarecommission.org.uk/improvement/interviewchildrens.

There are a number of questions (see page 46) that trusts may wish to consider, in order to assure themselves of the quality of the services they provide to children.

Recommendations for commissioners and to strategic health authorities

Commissioners and strategic health authorities must:

- ensure there is a sustainable regional network of services for children, by reviewing the level of work carried out by, and the locations of, hospitals that provide inpatient care and planned and emergency surgery (particularly for young children). If necessary, move services between local trusts or to regional trusts. Commissioners and strategic health authorities must work together to achieve this, notwithstanding reforms such as payment by results and patient choice
- establish clinical networks and improve 'outreach' from regional centres, particularly in surgical specialities, to maintain local expertise
- support trusts to train their staff by giving proper priority to training in the care of children in workforce planning and development programmes, and identifying appropriate locally provided courses
- strategic health authorities with responsibility for managing the performance of NHS trusts should ensure that each one has an action plan addressing all areas of weakness identified in the Healthcare Commission's individual trust assessments.

Recommendations for professional bodies

Professional bodies must:

- press for the improvement of services for children, in line with the recommendations in this report, and promote local leadership of improvement among members
- ensure that the requirements for pre-registration training include appropriate training for and exposure to paediatric cases, including the basics such as paediatric life support and basic communication skills
- continue to be clear about the minimum requirements for initial and refresher training in children's care and the level of work professionals should be carrying out in order to maintain their competence to work with younger children. This should be communicated to members and reinforced during all visits by professionals to trusts

Questions for boards of NHS and foundation trusts

- Have all services accessed by children across the trust been identified?
- Have all staff (including surgeons and anaesthetists) who work with children across the trust been identified?
- Is there a single structure for performance management that monitors all services provided to children, inside and outside paediatrics?
- Has responsibility for improving children's care been allocated within surgical, emergency and critical care directorates?
- Are clinical directors supported in order to improve the delivery of services for children?
- Is the trust aware of its position on basic training in all services: basic paediatric life support, basic child protection, communication skills and, for nurses, pain assessment?
- Have all staff who need advanced training in life support or child protection been identified?
- Are there central records of training for all staff working with children (including surgeons and anaesthetists), and are records audited?
- Are there local training plans, starting with the staff in greatest need?
- Has the trust developed child-only services wherever possible?
- Are the majority of children's operations on child-only lists?
- Has the trust reduced the number of services access by children?
- Has the trust employed practical measures to focus services, such as segregated waiting areas and grouping of children's appointments and operations at the start of clinics or surgical lists?
- Has the trust compared the number of staff who specialise in play with other trusts and ensured that there is sufficient expertise locally?
- Are surgeons and anaesthetists working within their competence (for example, working with infants, young children or only older children)?
- Do all surgeons and anaesthetists working with young children treat enough children of all ages to maintain their skills either in the local trust, or by rotation into regional trusts?
- Does each hospital providing inpatient, surgical or emergency care have staff onsite who are trained (to advanced paediatric life support or equivalent) to deal with serious paediatric emergencies during the day and night?
- Where emergency attendances of children are low, including in urgent care centres, are protocols to treat children in place, do staff regularly practice emergency scenarios and do they receive refresher training in at least basic paediatric life support?
- Can a sufficient number of surgeons maintain their competency to provide an emergency rota for younger children in each speciality and, if not, what arrangements are in place?
- Have networks with other local trusts and regional providers been established? These should cover: care pathways and protocols on a speciality and condition basis (agreeing how and when children should be treated in each trust); rotation of staff into the regional trust; outreach surgery and outpatient care from the regional trust; and ongoing review of service sustainability.

Next steps

Work with trusts most in need of improvement

The Healthcare Commission has already worked with the 10% of trusts deemed most in need of improvement, based on the findings of the review. These trusts drew up action plans over the summer of 2006, which addressed the areas of weakness identified in our individual trust assessments. The Healthcare Commission's regional staff will be checking progress against these plans, but responsibility for managing the performance of the trusts lies with strategic health authorities or, in the case of foundation trusts, with the boards of trusts. The Healthcare Commission has also asked for further assurance from trusts that did not demonstrate they had sufficient cover to provide emergency life support to children.

Improvement at all trusts and across regions

This report highlights a number of continuing concerns and we expect all trusts, commissioners and strategic health authorities to ensure that its recommendations are met in full.

All trusts should develop plans based on the areas of weakness identified by their assessments: boards are responsible for setting these plans and ensuring that they are achieved. Boards of foundation trusts are also required to inform Monitor if the trust is at risk of failing to improve in any areas of concern identified by this review.

Strategic health authorities have a responsibility to hold all trusts (except foundation trusts) to account for improvements. They, with commissioners, will also be expected to lead planning at a regional level.

Our local assessment managers will check that trusts are addressing poor performance and our regular discussions with strategic health authorities will ensure that our recommendations are accounted for in their systems for managing performance and planning.

Collection of follow-up indicators

The Healthcare Commission will continue to promote improvement by collecting key information each year from 2006/2007. This information will be collected through the child health mapping project at Durham University. It will be used to create a small number of indicators to measure performance (Table 6).

The indicators were chosen from the improvement review's broader set of indicators, focusing on those areas most in need of improvement. They will be published and will allow the Commission to identify improvement. They will also contribute to our assessment of performance in relation to standards, and will be used to target further activity and planning for improvement.

Table 6: Follow-up indicators that will be used to track improvements in hospital care for children	
Indicator	Source
Emergency care	
Proportion of registered nurses (registered nurses and registered child-branch nurses) who have the essential training for emergency care: child protection level one, child protection level two, basic paediatric life support or paediatric life support	Child health mapping
Proportion of registered nurses (registered nurses and registered child-branch nurses) that have the necessary training for emergency care: advanced paediatric life support or equivalent, pain assessment, administering analgesia	Child health mapping
Day case care	
Proportion of registered nurses (registered nurses and registered child-branch nurses) who have the essential training for day case care: child protection level one	Child health mapping
Proportion of registered nurses (registered nurses and registered child-branch nurses) who have the necessary training for day case care: child protection level two, basic paediatric life support or paediatric life support, advanced paediatric life support or equivalent, pain assessment, administering analgesia	Child health mapping
Outpatients	
Is there at least one registered child-branch nurse working in each outpatient facility when it is open?	Child health mapping

Table 6 continued	
Surgery	
Proportion of all surgeon consultants working with children who are trained in essential training courses: child protection level one, basic paediatric life support or paediatric life support	Child health mapping
Proportion of all anaesthetist consultants working with children who are trained in essential training courses: child protection level one, advanced paediatric life support or equivalent	Child health mapping
Number of consultant anaesthetists carrying out very low levels of work with children (risk indicator) as a percentage of all consultant anaesthetists carrying out work on children in the trust	Child health mapping
Number of consultant anaesthetists anaesthetising infants aged less than six months (emergency or elective cases) as a percentage of the total number of consultant anaesthetists in the trust	Child health mapping
Number of consultant surgeons' teams carrying out low levels of work with children (risk indicator) as a percentage of all surgeon teams carrying out work on children in the trust	Hospital episode statistics
Play staff across a whole hospital site	
What is the extent of qualified and assistant play staff cover on the hospital site, when compared with workload? Headcount, divided by throughput of children aged 0-16 in day case care and inpatients	Child health mapping

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This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

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