Back to Facing the Future:

An audit of acute paediatric service standards in the UK

April 2013

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

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Foreword

Back to Facing the Future begins with the pithy phrase, 'Two years is a long time in the NHS'. Much has happened in the intervening period, not just in the NHS, but also within the wider economic, social and cultural environment in which it operates. Despite, or perhaps because of turbulence within the system, these standards for acute paediatric care have gained a great deal of currency; in fact, one of the phrases that leaps out from the report is that they have won the hearts and minds of paediatricians across the UK. We hope that this will continue to be the case, and that paediatricians will see them not just as standards to strive toward, but as a tool to use in their negotiations with commissioners and managers. Most importantly, they should represent a standard of care our patients, families and carers can expect from the doctors looking after them.

But that does not mean that we can be complacent. This audit highlights a number of concerns that the service will need to address if it is to provide the highest possible quality of care to children and young people across the UK. Quite rightly, paediatrics has frequently prided itself on being a seven-day specialty, so perhaps the most important area of concern is consultant presence at times of peak activity. It is an anomaly that when our units are at their busiest, the most experienced and skilled members of the team are not necessarily present in the vast majority of units. This is consistent with recent news stories concerning the service that the NHS provides during the evening and the weekend. We fully recognise the pressures on acute paediatricians within the current structure and configuration of services, but believe that this audit demonstrates that we have to be prepared to re-examine the way in which we deliver care. It is apparent from our audit, as it was when we drafted the standards, that there are too many units in the UK to provide a safe and sustainable service. Reconfiguration needs to happen to deliver the best possible care to children and young people.

This audit of the 10 acute paediatric standards has given us a great deal of food for thought as to how we might deliver care in more innovative, effective and efficient ways. RCPCH now has a responsibility to build on the progress that we have made with *Facing the Future*, and to support local service providers in finding the solutions to the challenges that they face. Brave and creative leadership will be essential if we are to move forward together in the best interests of children, young people and their families.

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Acknowledgments

RCPCH is extremely grateful to the units who took part in the audit, particularly to the staff interviewed at the units visited by the audit team.

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Abbreviations

AoMRC	Academy of Medical Royal Colleges
APNP	Advanced Paediatric Nurse Practitioner
CCG	Clinical Commissioning Group
CPD	Continuing Professional Development
CYPHOF	Children and Young People's Health Outcomes Forum
EWTD	European Working Time Directive
GMC	General Medical Council
LAT	Local Area Team
NHS CB	NHS Commissioning Board
PCT	Primary Care Trust
RCOG	Royal College of Obstetricians and Gynaecologists
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCSEng	Royal College of Surgeons of England
SCG	Specialised Commissioning Group
SSPAU	Short Stay Paediatric Assessment Unit
WTE	Whole Time Equivalent

Executive Summary

Background and context

When the Royal College of Paediatrics and Child Health published its 10 standards for acute paediatric care *Facing the Future: A Review of Paediatric Services* (referred to as *Facing the Future*) in April 2011, the Health and Social Care Act was in the midst of its unprecedented 'listening exercise', Andrew Lansley was Secretary of State for Health and the Francis Inquiry had yet to report. At that time, *Facing the Future* was a bold but necessary step forward for a royal college. Its interlocking recommendations - that the number of paediatric inpatient units is reduced and that consultant numbers are increased whilst training numbers decreased to improve patient care - went far beyond the typical reticence of the medical professions to recommend system change.

On page six of *Facing the Future*, the RCPCH committed to audit the 10 standards for acute paediatrics, and this report is delivering on that promise. The purpose of the audit was two-fold. Firstly, to assess compliance against the standards across the UK and, through this process, build up a comprehensive picture of paediatric provision throughout the four nations. Secondly, and perhaps more vitally, the audit intended to assess the impact of the standards themselves.

The audit was carried out over the summer and autumn of 2012, in two stages. The first stage was a general survey of all the UK's acute paediatric units, asking them 32 questions about the 10 standards, and asking them to conduct a retrospective case note analysis on 20 admissions, dating from 1 March 2012. The second stage of the audit was a series of 'deep-dive' visits to 14 units across England, Northern Ireland, Scotland and Wales. These visits involved a series of structured interviews, typically with the clinical lead; nurse or ward manager; and up to two trainee paediatricians.

Findings

When the College published *Facing the Future* in April 2011, we could not have hoped for the impact that the standards have manifestly had on the service since. They have won the hearts and minds of paediatricians, and are being used on a daily basis by them both to reflect on their own practice and also to advocate for better care with their colleagues in hospital management and in clinical commissioning groups. It is a credit to the diligence and dedication of the paediatricians, nurses and other health professionals who work to deliver high quality care for children and young people that most of the time, most of the standards are being met across the UK.

However, this audit has highlighted that these standards are not being met as regularly at weekends and evenings as they are between the hours of 9am and 5pm. At times of peak activity, when one would expect the standard of service to be at its most robust, the most senior, skilled and experienced staff are not always present. It is essential that paediatrics is a 24/7 specialty, and consequently service planners should organise rotas more carefully around the needs of the child. This will require careful job planning, but the principles outlined in *RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital* are paramount, and its echo of the Medical Schools Council, Consensus Statement on The Role of the Doctor; that 'the role of the doctor must be defined by what is in the best interests of the patients and the population served'[1].

On some of our unit visits we discovered strong support for the standards which nonetheless sat alongside a belief in some quarters that they could be selectively chosen and concentrated upon. Furthermore, the service is occasionally dependent on informal working relationships

[1] RCPCH (2009) *RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital*

rather than robust, standardised network arrangements. These relationships rely on the hard work and commitment of paediatricians to go above and beyond the call of duty, and this seemed widely prevalent. However making things work in adverse conditions also masks the need for urgent reconfiguration of services, to ensure that paediatric services continue to provide the highest quality standards of care, and that children and young people are treated in the right place at the right time.

One of the objectives of the audit was to assess whether data is being collected that demonstrates the quantitative impact that *Facing the Future* standards are having upon outcomes. The successful implementation of *Facing the Future* appears in some instances to have had the unintended consequence of discouraging the measuring of outcomes or self-auditing against the standards. As we have stated, there is an irony that those units which do not meet the standards for whatever reasons, have taken the initiative to ensure that their service is safe and sustainable by implementing robust audit and data collection programmes. It is essential that in those units where the standards are being met, this good practice is mirrored.

Back to Facing the Future highlights many areas where clinical directors and paediatricians can reflect upon in order to continually improve the quality and safety of the service that they provide to meet the standards and, more importantly, ensure that children and young people receive the best possible care. Clearly there is also more work for the College to do in ensuring that the standards are met, but also following up on the implications of this report. As we reported when we first modelled the *Facing the Future* standards, there is no way in which the standards can be met with the current workforce, and with the current number of inpatient units. Children's health services cannot continue in their present form indefinitely. We will continue to look at more innovative models of service provision, providing more care in the community, whilst centralising expertise. The next stage of the *Facing the Future* project will look at developing these models, and how the standards impact on services across the local health economy. Two years is a long time in the NHS, and the next two will be particularly long. The College is committed to supporting it to face the future and ensure that children and young people receive the highest possible standards and outcomes of care.

Audit results summary

Standard 1	In the UK, 77.4% of children or young people admitted to a paediatric department with an acute medical problem are seen by a paediatrician on the middle grade or consultant rota within four hours of admission.
Standard 2	In the UK, 87.7% of children or young people admitted to a paediatric department with an acute medical problem are seen by a consultant paedatrician (or equivalent) within the first 24 hours.
Standard 3	99.2% of UK units have a rota structure which allows every child or young person with an acute medical problem who is referred for a paediatric opinion to be seen by, or have their case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner. In practice, this happens in 95.8% of units.
Standard 4	Of units with SSPAUs, 98.9% have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open, either in person or by telephone.
Standard 5	94.1% of units have at least one medical handover in every 24 hours led by a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
Standard 6	On weekdays, a paediatric consultant (or equivalent) is present in the hospital during times of self-identified peak activity in 25.6% of units. At weekends, a paediatric consultant (or equivalent) is present in the hospital during times of self-identified peak activity in 20.0% of units.
Standard 7	92.4% of units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
Standard 8	Across all rota tiers, 28% have 10 or more WTE.
Standard 9	Averaged across the eight subspecialties considered, 85.3% of units have access to specialist paediatricians for immediate telephone advice.
Standard 10	In 82.5% of units, all children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills of at least Level 3 safeguarding competencies 24 hours a day, seven days a week.

Recommendations

- The College will work further to encourage units to provide better consultant (or equivalent) coverage when they are at their busiest. It is essential that paediatrics is a 24 hours a day, seven days a week specialty, and consequently the service should be organised around the child's needs.

- The RCPCH will continue to have discussions with the Care Quality Commission about how the standards might be applied within a regulatory framework

- The College will continue its invited reviews programme, using the standards published in *Facing the Future* to provide a framework in which quality and safety are maintained in the system.

- Individual units need to improve their data collection around outcomes, and how these are impacted upon by meeting the *Facing the Future* standards.

- The RCPCH will conduct further research on the impact of the standards upon quality, safety and outcomes. *Facing the Future* was built by consensus, and has been accepted by the service as the minimum standard. What is now required is to move beyond that consensus to demonstrate improved outcomes for children and young people.

- The RCPCH urges consultants and trainees to maintain a dialogue around the standards and their impact on training, and ensure that it is not adversely affected.

- Urgent reconfiguration and new models of provision need to be explored, and these interfaces may well form the basis of future College work in the *Facing the Future* series.

- The Strategic Clinical Networks for Children and Maternity in England should make it an urgent priority to reduce the unwarranted variation in care that may well result from such arrangements. Equally, in the other three home nations health trusts will need to work together to ensure that specialty advice is consistently accessible.

- The RCPCH will be following up with units where standard 10 is not being met to ensure that there are adequate child protection arrangements across the UK.

- The RCPCH will continue to look at more innovative models of service provision, providing more care in the community, whilst centralising expertise.

Introduction

Two years is a long time in the NHS. When the Royal College of Paediatrics and Child Health published its ten standards for acute paediatric care *Facing the Future: A Review of Paediatric Services* (referred to as *Facing the Future*) in April 2011, the Health and Social Care Act was in the midst of its unprecedented 'listening exercise', Andrew Lansley was Secretary of State for Health and the Francis Inquiry had yet to report. At that time, *Facing the Future* was a bold but necessary step forward for a Royal College. Its interlocking recommendations - that the number of paediatric inpatient units is reduced and that consultant numbers are increased whilst training numbers decreased to improve patient care - went far beyond the typical reticence of the medical professions to recommend system change. They were vital in making the case for reconfiguration and, in the past 18 months, the Royal College of Physicians (RCP) and Royal College of Obstetricians and Gynaecologists (RCOG) have published *Hospitals on the Edge*[2] and *High Quality Women's Health Care*[3] respectively. These publications have reinforced the now commonly held perception that current models of provision are no longer sustainable. *Facing the Future* was amongst the first reports to unambiguously recommend a consultant delivered care model, triggering a growing consensus illustrated by a report by the Academy of Medical Royal Colleges (AoMRC)[4], articles in the British Medical Journal, and the College's own *Consultant Delivered Care: An evaluation of new ways of working in paediatrics*.[5]

On page six of *Facing the Future*, the RCPCH committed to audit the 10 standards for acute paediatrics, and this report is delivering on that promise. The purpose of the audit was two-fold. Firstly, to assess compliance against the standards across the UK, and through this process, build up a comprehensive picture of paediatric provision throughout the four nations. Secondly, and perhaps more vitally, the audit intended to assess the impact of the standards themselves. Are they supported on the frontline? Are they driving changes in service provision to ensure that paediatrics continues to operate safely and sustainably? And most importantly, are the *Facing the Future* standards improving the quality of care that children, young people and their families expect and are entitled to?

This project has gone a long way towards answering these questions, and has also unearthed interesting and innovative models of provision. Encouragingly, we can also confidently state that the *Facing the Future* standards have captured the hearts and minds of the majority of paediatricians. On our visits to units around the country clinicians were enthusiastic about the standards, and many were using them to reflect on their own practice, collaborate with other clinicians and managers to find solutions, as well as a tool to teach more junior staff.

The audit was carried out over the summer and autumn of 2012, in two stages. The first stage was a general survey of all the UK's acute paediatric units, asking them 32 questions about the 10 standards, and asking them to conduct a retrospective case note analysis on 20 admissions, dating from 1 March 2012. The second stage of the audit was a series of 'deep-dive' visits to 14 units across England, Northern Ireland, Scotland and Wales. These visits involved a series of structured interviews, typically with the clinical lead; nurse or ward manager; and up to two trainee paediatricians. The quantitative and qualitative data collected from these two stages is presented in more detail in Appendix 2, while more detailed methodology for the research is available in Appendix 1.

Of course, during these two years, as outlined above, the NHS in England has been through a radical reorganisation on the purchaser side. As this document goes to press, Clinical Commissioning Groups (CCGs), the NHS Commissioning Board (NHS CB) and its Local Area

[2] Royal College of Physicians (2012) *Hospitals on the edge? The time for action* http://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf
[3] Royal College of Obstetricians and Gynaecologists (2011) *High Quality Women's Health Care: A proposal for change* http://www.rcog.org.uk/high-quality-womens-health-care
[4] Academy of Medical Royal Colleges (2012) *The Benefits of Consultant-Delivered Care* http://www.aomrc.org.uk/item/benefits-of-consultant-delivered-care.html
[5] *'RCPCH (2012) Consultant Delivered Care: An evaluation of new ways of working in Paediatrics'*

Teams (LATs) will be formally taking on the responsibilities previously undertaken by Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and Specialised Commissioning Groups (SCGs). Furthermore, major changes to the education and training of health professionals with the creation of Health Education England and Local Education and Training Boards (LETBs) have resulted in further churn for the service. Undoubtedly, this period of transition has had a destabilising effect on the provider side, but paediatric services have for the most part been incredibly resilient. Nonetheless, at a time when RCPCH believes radical transformation of the way in which we deliver care, such system change may be a distraction at best.

Background and context

The College developed the initial *Facing the Future* standards in November 2010. These were published and sent to every member, and are repeated below:

1. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.
2. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.
3. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
4. All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
7. All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.
8. All general acute paediatric rotas are made up of at least 10 WTEs, all of whom are EWTD compliant.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

These standards were closely followed, in April 2011, by *Facing the Future: A Review of Paediatric Standards*, which reiterated the standards and provided workforce and service provision modelling around their implications. The report's conclusions, viewed from the perspective of royal colleges' normal reticence to engage in these issues, were bold but necessary; the five key interlocking recommendations were the following:

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Certainly at the time, this was an unusual position for a royal college to take. Whilst expansion of the consultant workforce was a familiar cry, the other four (and interdependent) recommendations were not. A reduction in the number of trainees and inpatient sites went against the grain of the medical profession orthodoxy (and to a certain extent public opinion), whilst the remaining two recommendations also went beyond the confines of RCPCH's nominal influence.

From another perspective, and as the report's authors were at pains to make clear throughout, *Facing the Future* stopped short of yet more radical solutions and envisaged the changes outlined to be implemented over a five to 10 year period. Importantly, the report very much

intended this analysis to remain 'live' and non-static, flexible to the changes afoot in the health system.

Indeed, all of the recommendations have led to change in the last 24 months, both at an operational and policy level. Taken in turn, and starting with the most controversial, the debate over reconfiguration has reached fever pitch. As this report is written, the battle over the potential downgrading of Lewisham Hospital's Emergency Department is raging, in the national press and in the Houses of Parliament. Regardless of the rights or wrongs of that particular set of circumstances, the clamour for reconfiguration (with the attendant caveats) has also increased elsewhere. When *Facing the Future* was published, the College was somewhat of a lone voice. Since then, the King's Fund, the RCOG, RCP and the Royal College of Surgeons in England (RCSEng) have all published reports recommending the closure of some inpatient units to improve the quality and safety of care. After the collapse of Premier League footballer Fabrice Muamba mid-match with a cardiac arrest Mike Farrar, chief executive of the NHS Confederation, remarked that the decision to take Muamba to the best hospital rather than the closest was a decision that saved his life[6].

While these public conversations generally revolve around the configuration of urgent and emergency services (and the NHS CB has recently announced a review looking at models of care in this area[7]), there has also been a noticeable shift in the terms of the debate for acute secondary care. In other words, the health service is now firmly signed up to at least the principle of service reconfiguration, even if there continues to be a lack of clarity on the specifics, and consequently continuing fractious local discussions. *Facing the Future* remains the only national guidance document that provides some modelling on what a reconfigured acute service might look like. If, as Professor Norman Williams of the RCSEng recently wrote, 2013 is to be the year that 'patients, politicians, clinicians, and managers come together to support historic change in the NHS and create a long-lasting legacy for all of our population'[8], we trust that *Back to Facing the Future* will help to facilitate those critical discussions and more importantly, critical decisions.

The debate over consultant delivered care has also progressed, with the AoMRC publishing *The Benefits of Consultant-Delivered Care*. This looked at the available evidence and concluded that a consultant led service resulted in rapid and appropriate decision making, improved outcomes for patients, more efficient use of resources, improved GP access to the opinion of a fully trained doctor, satisfied patient expectations of access to appropriate and skilled clinicians and information, and reaped benefits for the training of junior doctors[9]. This report was shortly followed by *Seven Day Consultant Present Care* which made a key recommendation that hospital patients could expect to 'be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.' The RCPCH fully supports this recommendation, which is complemented by the *Facing the Future* standards, and would argue that this is yet more acute in paediatrics, a specialty in which the patients are admitted for shorter periods, but whose condition is less predictable and more likely to deteriorate quickly. Again, the health service seems to have reached a far broader consensus that a consultant led service is one that would be best for ensuring patients receive excellent care 24 hours a day, seven days a week. NICE has also recently started a workstream on Seven Day Working[10]. RCPCH made our own contribution in 2012 with the publication of *Consultant Delivered Care: An evaluation of new ways of working in paediatrics*. The report concluded that the 'resident shift working consultant model is central

[6] NHS Confederation (2012) 'NHS needs more Fabrice Muamba stories' http://www.nhsconfed.org/priorities/latestnews/Pages/NHS-needs-more-Fabrice-Muamba-stories.aspx Accessed 21 January 2013
[7] NHS Commissioning Board (2013) 'Sir Bruce Keogh to lead review of urgent and emergency services in England' http://www.commissioningboard.nhs.uk/2013/01/18/service-review/ Accessed 21 January 2013
[8] Williams, N (2013) 'Why 2013 is the moment for clinically led service change explains Professor Norman Williams' *NHS Voices* http://nhsvoices.nhsconfed.org/2013/01/07/2013-its-now-or-never-for-service-change-jeremy-hunt-must-deliver-says-norman-williams/ Accessed 21 January 2013
[9] Academy of Medical Royal Colleges (2012) *The Benefits of Consultant-Delivered Care* http://www.aomrc.org.uk/item/benefits-of-consultant-delivered-care.html
[10] NICE (2012) Stakeholder workshop: 7 day working – Service Delivery Guideline http://www.nice.org.uk/media/5D9/88/SevenDayWorkshop291112Summary.pdf Accessed 5 February 2013

to the achievement of the recommendations in *Facing the Future*'[11]. To some extent, this report intends to provide answers to the question of how comprehensively this model has been applied in meeting the standards.

Nonetheless, the implications of moving to this system need to be carefully thought through. Importantly, *Seven Day Consultant Present Care* was cognisant of the wider health economy with its second key recommendation: 'Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant led review, can be taken.' While the *Facing the Future* standards were firmly aimed at acute paediatrics and what happens to the seriously sick child when admitted to hospital, this report looks at their wider implications, and most particularly, how referral and admission patterns in secondary care are significantly influenced by primary care.

Facing the Future's third and fourth recommendations addressed matters beyond the RCPCH's immediate purview. The report recommended an expansion of registered children's nurses, and the numbers of those registered has risen steadily from 41,124 in 2010 to 45,186 in 2012[12]. However, this may not reflect the number of children's nurses in post and the issue remains a concern for the Royal College of Nursing (RCN) and UNISON. The RCN has published its own guidance on appropriate staffing levels for children and young people's services[13].

Since 2011, the RCGP's proposal to extend basic training for GPs from three years to four in order to accommodate greater exposure to paediatrics and children's health has gained traction, with its unanimous approval by Medical Education England in September 2012. The RCPCH has supported the RCGP at every step during this process and will continue to do so while the plans for affordability and implementation await approval by the DH in England, and the new curriculum and assessment system by the General Medical Council (GMC)[14].

The final recommendation of *Facing the Future* was regarding a reduction in paediatric trainee numbers. Since 2010 training numbers have not reduced as Table 1 demonstrates.

Table 1: Paediatric trainee numbers 2010 to 2013

Intake year	England		Wales		Northern Ireland		Scotland ***	
	Posts	Applic.	Posts	Applic.	Posts	Applic.	Posts	Applic.
2010*	350	707	15	38	N/A	N/A	37	153
2011	359	680	22	24	17	49	26	105
2012	357	679	15	20	15	36	34	109
2013**	352	684	21	31	15	30	33	64

* applicant figures for 2009/2010 are based on candidates' first preference deanery
** 2013 figures are provisional
*** Scotland numbers are not comparable to elsewhere in the UK for the last three years due to a spread of ST1 and ST2 level with approximately 40% intake in ST2 (providing opportunities for ST2 entry for ST1 LATs)

These numbers show that as yet there has been no concerted effort to decrease trainee numbers. In England, a review of the paediatric workforce by the Centre for Workforce Intelligence (CfWI) and other agencies is needed urgently in the next year to provide some clarity for future workforce planning and the RCPCH is willing to work closely with the CfWI and other UK workforce planning bodies on this project to ensure a paediatric workforce fit for the future.

[11] RCPCH (2012) *Consultant Delivered Care: An evaluation of new ways of working in Paediatrics* p.8
[12] Nursing and Midwifery Council, personal communication
[13] Royal College of Nursing (2003) Defining staffing levels for children and *young people's services: RCN guidance for clinical professionals and service managers* http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf
[14] Medical Education England (2012) 'MEE supports educational case for extended GP training' http://www.mee.nhs.uk/latest_news/news_releases/supports_extended_gp_training.aspx Accessed 21 January 2013

Of course, while these are questions over which paediatrics has been wrestling, they are somewhat overshadowed by three key challenges which the wider NHS, at least in England, has been dealing with. The first of these is the implementation of the changes brought about by the Health and Social Care Act 2012, which has significantly reshaped the purchaser side of the NHS. The second is the on-going so-called 'Nicholson challenge' in which £20 billion in efficiency savings need to be found by 2015. This is a proxy way of saying that times are tight in the NHS and are likely to be getting much tighter post-2015, and that this is as apparent in paediatrics as it is elsewhere. The final challenge is that posed by the Robert Francis QC's recently published report. While the focus of Francis' inquiry was on adult care, nonetheless the Royal Colleges' general role in whistleblowing and quality and safety maintenance was closely scrutinised. The College has responded to these challenges through our invited reviews programme, and the standards published in *Facing the Future* are intended to provide a framework in which quality and safety are maintained in the system.

Auditing Facing the Future

These macro challenges were the context for the audit of the *Facing the Future* standards, carried out in the latter half of 2012. With the publication of the Children and Young People's Health Outcomes Forum (CYPHOF) in July 2012 the timing was apt, and the RCPCH hopes the recommendations of this report will complement the government's response in February 2013.

The immediate concern of the audit was the impact that the standards have had on the service. The audit received a 69.5% (n: 121) response rate, and the feedback from the unit visits that the team received was almost unanimously positive in terms of the principles behind the standards.

> *"They were useful to read and assess how we would cope with it. They are what we want in terms of service standards."*

The standards have achieved a high degree of penetration, with every clinical lead on every visit being fully aware of the standards and having discussed them with his or her team, while at a more junior level, 90% of trainees interviewed were familiar with the standards or the principles behind them. This support was reiterated across the board by safeguarding leads, trainees of all levels, nursing leads and ward managers.

Indeed, the challenge in some regards is whether the standards could be yet more robust. The opinion that the standards could be incorporated into a regulatory framework was repeated on a number of unit visits. It was felt by some interviewees that incorporation of the standards within this framework would help to draw the standards to commissioners, and senior hospital management's attention and in the process highlight the perceived shortfall in children's healthcare compared to adult care. To a certain extent, the standards have been integrated in service specifications for commissioners which should help to embed them further. This view contrasted however with the unease felt by some units that weren't meeting the standards, about their application in a legal context. RCPCH would like to find a balance between these two viewpoints, and we have had discussions with the Care Quality Commission about how this might be achieved, and will continue to do so.

There was further divergence of opinion on to what extent the standards were adopted by units. Some units were fully signed up to all of the standards, treating them as the bare minimum for service provision, while others, supportive of the principals of the standards, nonetheless felt that some were more applicable than others. In other words, they placed greater emphasis on some standards whilst disregarding those that they felt were either too difficult to achieve, or had concerns about applicability to their unit. The *Facing the Future* standards are intended to be pragmatic minimum guidelines that are achievable by every acute paediatric service in the UK. Nonetheless, we agree that they can only ever be a blunt instrument, and should complement a clinical director's assessment of the needs of their service. The near impossibility of setting 10 standards to cover the breadth and depth of paediatric provision across the UK has inevitably resulted in some units feeling that they don't go far enough, while others struggle to meet some. The RCPCH has always intended that these standards are part of a discussion, rather than a diktat. This does not take away from their status as minimum standards. We believe they are appropriate for every unit in the UK, but we want to support and prompt conversations with units that do not meet the standards. They should also serve to facilitate discussions between neighbouring units on how the standards might be met by working as a bigger team in network configurations. The RCPCH's recent publication *Bringing Networks to Life* includes a toolkit with a number of questions for clinicians to consider in this context[15].

It was also heartening to meet many clinicians throughout the audit who were completely committed to the care and health of the children and young people that were under their supervision. Their dedication and passion was self-evident, but may mask a system that is

[15] RCPCH (2012) *Bringing Networks to Life – An RCPCH guide to implementing Clinical Networks* http://www.rcpch.ac.uk/system/files/protected/page/Bringing%20Networks%20to%20Life%20for%20web_0.pdf

unsustainable and unsafe in the longer term. Radical change is needed to support those working in the service and the children and young people that they care for.

It was a disconcerting irony to discover that many of the significant minority of units that were not meeting standards often had the most comprehensive data collection, in an effort to prove to potential litigants that despite not meeting the 'letter of the law', they were still providing a safe and sustainable service. This contrasted with the great majority of units that were comfortably meeting all or most of the standards, but had little or no quantitative evidence that their compliance meant safer or higher quality care for their patients. One of the aims of the audit was to assess whether data was being collected that would show whether or not *Facing the Future* was improving care. At the majority of units visited, this was not the case. This chimes with the CYPHOF's findings that lack of data and poor quality data has hindered progress in paediatrics. It is now incumbent upon the units to improve their data collection, and also upon RCPCH to conduct further research on the impact of the standards upon quality, safety and outcomes. *Facing the Future* was built by consensus, and has been accepted by the service as the minimum standard. What is now required is to move beyond that consensus to demonstrate improved outcomes for children and young people.

Standards 1, 2 and 3

The first three standards of *Facing the Future* are the foundation upon which the others are built. Across the UK, the audit demonstrated that a child or young person admitted to a paediatric ward is seen by a paediatrician on the middle grade or consultant grade within four hours of admission, on average, in 77.4% of cases (see Figure 1).

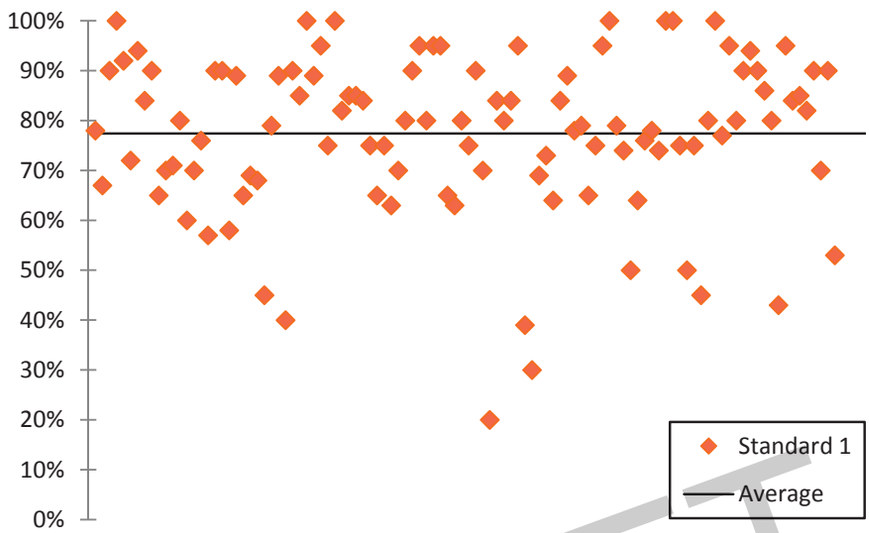

Figure 1: Compliance with standard 1 - all units (n=106)

In 87.7% of cases reviewed, the child or young person was seen by a consultant or equivalent within 24 hours (see Figure 2). Parents, families and patients can therefore be reassured that in the majority of cases, they are seen by an appropriately trained clinician who will give them the best possible care.

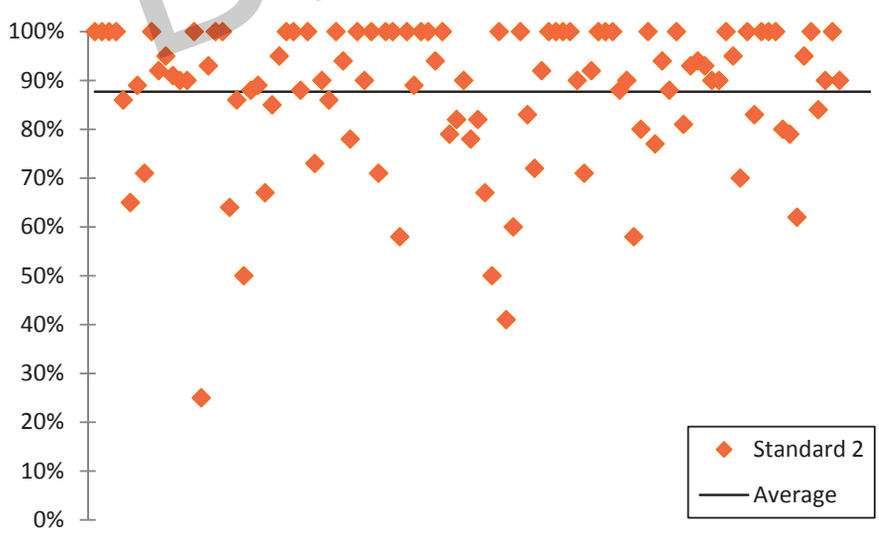

Figure 2: Compliance with standard 2 - all units (n=106)

Nonetheless, these figures mean that just under a quarter of admissions are not seen by an appropriately trained clinician within four hours. Whilst this might initially be a cause for concern, a number of explanations shed light on these apparent failures in care. The first explanation is that standard one clearly states that it applies to the child with an acute medical problem. In the audit, RCPCH asked units to conduct a retrospective case note analysis on 20

admissions, and no guidance was provided on assessing the acuity of the patient's condition. Therefore it is probable that in some of these cases the collective clinical judgement was that the child's condition could be comfortably managed without the direct intervention of a middle grade doctor. Nonetheless, the account of one clinical director who we visited provides a sobering case study:

> *"A Serious Untoward Incident (SUI) occurred due to failings of standard one, even though a Paediatric Early Warning System score has been put in place. A child died because the SHO did not recognise the red score. The SpR was falsely reassured and the consultant stayed at home. This SUI would have been dealt with had they been seen by the SpR within four hours."*

When conducting the deep-dive visits clinical directors and doctors on the middle grade were quick to provide reassurance that they were kept fully apprised of every patient admitted, and would of course attend to the patient in person should their condition deteriorate. The data that we received on the third standard pertains directly to this question, and offers further reassurance. 100% of units have a system in place to ensure that every child referred has their case discussed with at least a doctor on the middle grade; in practice, this worked in 95.8% of units. The explanation given for the few units that didn't meet this standard were either that they occasionally used an ST3 doctor who they felt had sufficient experience on the middle grade rota, or that some of the referrals they received from primary care, particularly out-of-hours, were for very straightforward conditions and could consequently be dealt with by a less experienced trainee. Nonetheless, there is a lesson for units to consider consultant support of the decision-making of less experienced trainees, who may not know when it is appropriate to call the consultant, as in the case study above.

Connected to this point, we also looked at compliance with the small print of standard one, which states that when a child is seen by a ST3 trainee on the middle grade, they are then reviewed by a consultant within 12 hours. It is concerning that in the vast majority of cases, this recommendation was not observed, and there was little difference between the time that a consultant would review a patient following examination by a ST3 trainee, or one at ST4 or above, as Table 2 illustrates. Indeed, in the daytime, a child seen by a doctor at ST4 or above was seen by a consultant within 12 hours 34% of the time, compared to 27% of the time for a patient initially seen by a ST3 doctor. We also reviewed whether children were being seen by a consultant within 12 hours, irrespective of review by another doctor, something that RCPCH Council had considered when drawing up the *Facing the Future* standards, and also a standard that NHS London have recently introduced locally for emergency care. Compliance with this measure was comparatively good with night admissions (57%), probably as a result of the patient being seen on the morning ward round, while in the day and the evening it was poor; 26% and 17% respectively. Where this standard was met, it was generally as a result of implementing two ward rounds a day and twilight shift model for the consultant of the week. Arguably a strengthening of the *Facing the Future* standards in this regard would encourage such a system to be implemented.

Table 2: Percentage of admissions seen by consultant within 12 hours when first seen by ST3 doctor and ST4 or above

	% of admissions seen within 12 hours		
	First seen by ST3 doctor	**First seen by ST4 and above (or equivalent)**	**All admissions**
Day	20%	30%	26%
Evening	13%	19%	17%
Night	54%	60%	57%
Overall	**27%**	**34%**	**31%**

We also looked closely at how the size of a unit might affect their compliance with the *Facing the Future* standards. Very small units found it marginally easier to comply with standards one and two (see Table 3), a possible explanation for which is that they deal with a smaller number of admissions.

Table 3: Compliance with standards 1 and 2 by unit size

	Compliance with standard 1	**Compliance with standard 2**	**Number of respondents**
Very small	83.0%	93.4%	5
Small	79.0%	88.0%	22
Medium	75.4%	86.4%	56
Large	79.0%	88.8%	22
Overall	**77.4%**	**87.7%**	**105***

*Size data was not available for one unit

As one might expect, very small and small units had smaller rota sizes across the tiers (see Table 4), but on the other standards, there was little discernible difference in performance across unit size.

Table 4: Average WTE on the rota by unit size

	Average WTE on tier 1 rota	**Average WTE on tier 2 rota**	**Average WTE on tier 3 rota**	**Number of respondents**
Very small	9.0	6.7	7.5	5
Small	7.5	8.5	7.1	22
Medium	9.5	8.6	7.4	56
Large	10.6	10.1	8.4	22
Overall	**9.3**	**8.9**	**7.8**	**105***

*Size data was not available for one unit

The location of the paediatric ward in relation to the neonatal unit or Emergency Department also seemed to be a crucial determinant of how quickly a child is seen. In hospitals where there were shared rotas between neonatal and paediatric units, and these were co-located, the four hour target was easier to achieve. For those where the neonatal unit was on a different floor, or even a different site, it was far more difficult to achieve. For example, if a middle grade doctor had to attend to a sick baby in neonatal care for several hours, it would be difficult to have sight of a comparatively well child in the paediatric ward some distance away.

Similarly, when conducting the visits we also discovered that some larger units frequently split their morning ward round between the consultant and an experienced trainee. The consequence of this is that some relatively stable and well children would not be physically seen by a consultant for at least 24 hours. Again, the units concerned were keen to reassure us that if the trainee had any serious anxieties about any of the patients on the ward round, this would be conveyed to the consultant who would then see the child and take appropriate action.

A minority of trainees expressed a view that the emphasis in the *Facing the Future* standards on consultant-delivered care could potentially be disempowering for them in terms of their own decision-making and experience. While we are conscious of this potential unintended consequence of the standards, we were also reassured by other trainees who saw their personal development as their individual responsibility, and consequently their prerogative to discuss the matter with their supervising consultant if they felt their training needs were not being addressed. They also felt that increased consultant presence actually gave them both increased supervision and an opportunity to learn directly from more experienced staff, and in that way increased their confidence and training experience. Involvement in the medical handover was also seen as a key training opportunity. Clearly the *Facing the Future* standards were in part developed to facilitate and protect the training of the current and future paediatric workforce, and we believe the eighth standard around adequate numbers of doctors on each tier of the rota will facilitate this. We would urge consultants and trainees to maintain a dialogue around the standards and their impact on training, and ensure that it is not adversely affected.

But perhaps the most important finding in our audit of these first three standards was the disparity between the care that is delivered during the day, the evening, and the night. If paediatrics has ambitions to be a 24 hours a day, seven days a week specialty, it still has some distance to travel. Compliance with standard one, regarding a patient being seen by a middle grade within four hours, was weaker at weekends (73.4%) than on weekdays (79.2%).

Table 5: Average compliance with standard 1 and 2 on weekdays and at weekends

	Av. compliance with standard 1	Av. compliance with standard 2
Weekdays	79.2%	88.9%
Weekends	73.4%	85.0%
Overall	**77.4%**	**87.7%**

Similarly, for nights (considered 10pm-9am, 69.8%) compliance is weak, compared to the daytime (considered 9am-5pm, 80.4%) and the evening (considered 5pm-10pm, 80.1%). Compliance with standard two, regarding a patient being seen by a consultant within 24 hours, was weaker at weekends (85% UK compliance) than on weekdays (88.9%). There was little difference between night-time (85.6%) and daytime (86.3%) for this standard, and in fact in the evenings it was met 91% of the time, perhaps reflecting that most children admitted in the night will be seen by the consultant the next morning on the ward round.

Table 6: Average compliance with standard 1 and 2 by time of day admitted

	Av. compliance with standard 1	Av. compliance with standard 2
Day	80.4%	86.3%
Evening	80.1%	91.0%
Night	69.8%	85.6%
Overall	**77.4%**	**87.7%**

Table 5 and Table 6 indicate that there may be a problem with consultant presence, or even middle grade presence, at night and weekends. In a service where the patient both doesn't choose when they fall ill and may deteriorate quickly, a senior opinion is essential in ensuring that the child or young person receives the best possible care, regardless of the hour on the clock.

Consultant presence at peak times

This issue is highlighted even more starkly by our findings regarding standard six, which is concerned with consultant presence at times of peak activity. Based on our research and consensus amongst senior paediatricians, 5pm until 10pm was considered 'peak hours' by the *Facing the Future* standards. During this time, only 11% of units surveyed had consultant presence for this entire period on weekdays. Likewise, on weekends, consultant presence for the totality of those five hours was a mere 6%. Nonetheless, we then considered that many units may have different peak hours from those stated by *Facing the Future*. We asked units to assess consultant presence for self-identified peak times. The results are better, but still discouraging. Consultant presence was 26% during weekday peaks, and 20% on weekends.

This is in stark contrast to the compliance with standards five and seven, regarding medical handover, and an attending consultant system (most commonly in the form of a 'consultant of the week'), which is almost universal. In terms of handover, 94.1% of units in the UK performed one, led by a consultant, at least once a day. In many units that we visited, this was sometimes performed as often as three times a day, and included senior members of the nursing team, to ensure that the whole team was as up to date and involved as possible in the care of the children under their jurisdiction. There was strong support for this system, and many clinical directors and ward managers felt that an inclusive, well-documented handover was the glue that held the service together on a daily basis. Likewise, the attending consultant system was strongly supported across the UK, with 92.4% of units having this in place, and 97.2% of those units implementing it over two weeks in July 2012. This system is most commonly realised in the form of 'consultant of the week'; the consultant scheduled for that week cancels all his or her scheduled clinics to ensure that they are available throughout that week to lead the ward round and deal with urgent cases. Again, this had been introduced in many of the units we visited over the last five to ten years, and was widely felt to have underpinned a more integrated approach and greater continuity of care.

> *"It is a way of ensuring continuity of care. Treatments started on day one were getting changed on day two and three, which is not good for patient care and causes confusion for nurses etc. Consultant of the week allowed someone to be present on the shop floor for emergencies and continuity of care. It also allows us to accommodate changes to junior rotas that were being imposed on us."*

Amongst clinicians who took part in the system, it was acknowledged as a tough but rewarding week, with greater engagement in the unit's caseload and a positive effect on re-admissions and waiting lists.

> *"Having the consultant making the decisions means that there are fewer patients returning to out-patients, and out-patient waiting lists have reduced. Additionally, rates of re-admissions have reduced as consultants are making decisions."*

This is clearly a huge achievement for the service, and many of our interviews with clinical directors confirmed the consensus that these twin progressions had improved the quality, safety and efficiency of the service. The intention of the *Facing the Future* standards is that they are supportive of and interdependent upon each other. It is consequently surprising that whilst the groundwork has been laid with standards five and seven, standard six concerning consultant presence during peak activity is failed by the vast majority of units. In many other industries, it would be an anomaly that the most senior, experienced and skilled professionals were absent during the busiest periods. Regrettably, this appears to be common practice in paediatrics.

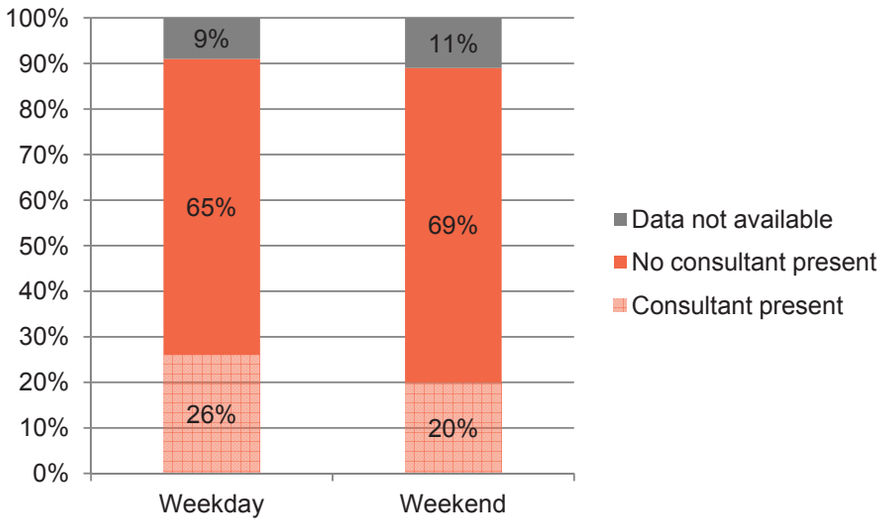

Figure 3: Consultant presence during self-defined peak hours

However, we might perhaps note that this is also reflective of wider clinical cultures; as noted in the introduction, much progress has been made in terms of making the case for 24 hours a day, seven days a week consultant-led services, but this is perhaps not reflected more widely in the service. Nonetheless, our purpose here is to comment on our specialty, and as the College has previously noted in *Consultant Delivered Care:* 'Paediatrics is, by its nature a 24/7 service. As every paediatrician, parent or carer knows the nature of childhood illnesses is that very often there is rapid progression of symptoms and increasing severity of illness in a very short space of time.'[16] The AoMRC noted that consultant delivered care facilitated rapid and appropriate decision making, improved outcomes for patients and more efficient use of resources[17]. Similarly, our research indicated that consultant delivered care results in improved team working, improved quality of care, ensures continuity of care, and can even provide a good life/work balance for clinicians[18].

When confronted with evidence around a failure to meet standard six, many clinical directors and nurse managers were naturally keen to defend their service, pointing out that consultants were accessible by telephone, worked later than their contracted hours, or that many lived nearby, and would have no hesitation about coming in to attend to an urgent case if required.

> *"There is an informal arrangement at the moment. There are some of us who having moved from other hospitals stay here. There are colleagues who live within five minutes of the hospital and feel that it is acceptable to go home during the evening."*

This may very well be the case, and the evidence that we have collected is not intended to question the professionalism of consultants, many of whom regularly go above and beyond the call of duty to deliver the best care possible for children and young people. However, the informality of these arrangements is concerning, and it may be a tough call for a nurse or a trainee to decide whether to bring in the consultant or not. The building blocks are in place to facilitate new ways of working to cover these peak periods in terms of the introduction of the 'consultant of the week' system and so it is puzzling that the service should fall so short across the board. To provide the highest quality and safe care to children and young people paediatrics needs to be a consultant delivered specialty and rota planning should reflect this. The College will work further on encouraging units to provide better coverage when they are at their busiest.

[16] RCPCH (2012) *Consultant-delivered care: an evaluation of new ways of working in paediatrics* p.6
[17] AoMRC (2012) *The benefits of consultant-delivered care*
[18] RCPCH (2012) *Consultant-delivered care: an evaluation of new ways of working in paediatrics* p.7

Connected to this workforce issue is our assessment of standard eight, another standard on which many units fell short. Standard eight concerns the number of whole time equivalent (WTE) paediatricians on a rota, and recommends that there are at least 10 on each tier, to facilitate meeting the European Working Time Regulation (EWTR), Continuing Professional Development (CPD), training time, and sufficient cover for unscheduled absence and staff vacancies. It is estimated from the College's rota vacancies and compliance survey that on Tier 1, there are 10.2% vacancies and gaps due to out of programme, and on tier 2, 16.3%[19]. Consequently, we acknowledge that this is a difficult standard to meet in practice. For tier one rotas, which are made up of foundation year doctors, grades ST1 to ST3, Advanced Paediatric Nurse Practitioners (APNPs) and GP trainees, only 30% of units had 10 or more on the rota. For tier two rotas, filled by trainee doctors on the middle grades of ST4 and above, the compliance was 32%. For tier three rotas of doctors at consultant grade or equivalent, compliance falls to 21%.

Although many clinical directors agreed that the standard was very useful in making the case for a safer and more sustainable hospital management, many believed it was unachievable in the current configuration of services.

> *"We are an enormous trust covering the whole of the county; there are three acute hospitals, two with inpatient paediatric units which are run entirely independently with separate on call rotas. Both are struggling to fill rotas. We feel that the logical answer is one large inpatient unit and a day assessment unit with consultant presence. The business case has been prepared and is currently going through process of approval; however there is a publicity campaign around the obstetrics department to keep both inpatient units open."*

This may also be having an impact, particularly on tier three rotas, with compliance with standards one, two and six. Clearly across the service, some difficult decisions need to be made to ensure that paediatric rotas are sufficiently and appropriately staffed, and that trainees receive appropriate training opportunities. The RCPCH commissioned some modelling in 2010 on how many WTE consultants are needed in practice (see Table 7), for different sizes of units, and this may be a useful tool as part of interim job planning.

[19] RCPCH (2012) *Rota vacancies and compliance survey findings December 2011 – March 2012* p.1.

Table 7: Whole time equivalent consultants required by unit size

Activity	Unit Size					
	SSPAU with cons cover**	24/7 Cons led SSPAU	Small/ v.small**	Small/ v.small with 24/7 cons	Medium	Large
Admin / SPAs per consultant	3.5	3.5	3.5	3.5	3.5	3.5
Subtotal 1	3.5	3.5	3.5	3.5	3.5	3.5
On-call PAs per week	9.0	9.0	6.75	0.0	9.0	9.0
Out-patient PAs per week	9.6	9.6	9.6	9.6	19.0	22.3
Ward round PAs per week	0.0	0.0	5.0	0.0	5.0	10.0
Community education PAs per week***	5.0	5.0	0.0	0.0	0.0	0.0
COTW PAs per week	0.0	10.0	10.0	10.0	17.5	17.5
On-site on-call (out-of-hours)	0.0	0.0	10.25	41.0	0.0	0.0
Sub-total 2	23.6	33.6	41.6	60.6	50.5	58.8
PAs for prospective cover @20%	4.7	6.7	8.3	12.1	10.1	11.8
WTE consultants required*	**4.4**	**6.2**	**7.7**	**11.2**	**9.3**	**10.9**

*WTE consultants required = (Sub-total 2 + prosp cover)/(10-sub-total1)
**These two columns represent extrapolations from the data supplied by the Manchester Children and Young Persons Network
***Community education represents the activity of consultants in educating local clinicians, particularly in regard to appropriate use of the SSPAU.

Nonetheless, as the original *Facing the Future* modelling demonstrated, this is just one reason why reconfiguration of services, and concentration of staff, is an urgent priority across child health services. The current system of provision is clearly unsustainable in the medium to long term, and its current high level of quality and safety is heavily reliant on the dedication and professionalism of the child health workforce.

Short Stay Paediatric Assessment Units (SSPAU)

These new models of working will need to engage with the whole system, across primary, secondary and social care. *Facing the Future* has been a lens through which we have viewed child health services; one that is focussed on the acute paediatric sector, but cognisant of the wider healthcare economy. One of the key tenets of RCPCH policy over the last five years has been the College's advocacy for SSPAUs.

Following our report published in January 2009, they are now an integral part of paediatric provision. Their function seems to be largely twofold. Firstly, to act as a pressure valve for the main paediatric unit. Surgical patients and patients awaiting transfer are commonly held in SSPAUs so that they do not take up valuable bed space in the main paediatric ward. Secondly, SSPAUs appear to act as a buffer to full admission for referrals for minor conditions from primary care or A&E. Some SSPAUs are co-located with A&E. 73.8% of units in England have a SSPAU, while in the other home nations, every unit surveyed had one.

When we visited units, support for the SSPAU was again strong, and clinical directors believed that they were an excellent way of managing capacity issues, and reserving bed space for those patients that most needed it. Indeed, some felt that without their SSPAU the unit could easily become overburdened by inappropriate referrals from either A&E or primary care. It was reported to the team that in some areas, A&E was being used by the local community as de facto primary care, either because of lack of faith by parents and carers in local primary care arrangements, or because they believed that is where they would receive the most appropriate care. The units in question have worked with the local healthcare economy on a programme of education and information around the most appropriate access points, but it was nonetheless a continuing source of frustration for clinical directors, not least because of the financial implications of admitting patients who might have been treated more appropriately in the community. Some units had found the use of Community Children Nurses (CCNs) a great help in this regard, but nonetheless current arrangements were still considered insufficient in some localities to adequately manage referrals.

> *"We are starting a new front of house pilot - putting APNPs in A&E, with the idea of sending children home who don't need to stay to improve patient flows. We have also expanded the community nursing team so we have more staff to follow up outside the hospital. We are planning, once the "front of house" arrangement is in place, to formalise arrangement for consultants to stay until 9pm."*

These interdependencies and synergies between services are yet further reason why urgent reconfiguration and new models of provision need to be explored, and these interfaces may well form the basis of future College work in the *Facing the Future* series.

Back to Facing the Future has highlighted how informal arrangements are in some instances keeping children's healthcare services going, and this was again in evidence in our study of compliance against standard nine, which is concerned with access to specialist paediatric opinion. The audit asked if specialist paediatricians were available for immediate telephone advice for acute problems across eight key specialties, and the extent of this compliance is outlined in Table 8.

Table 8: Availability of specialist paediatricians for immediate telephone advice

Specialty	Percentage of units with access
Endocrinology	77.7%
Gastroenterology, Hepatology and Nutrition	76.9%
Intensive Care Medicine	94.1%
Nephrology	89.3%
Neurology	86.0%
Oncology	90.9%
Paediatric Cardiology	90.9%
Respiratory Medicine	76.9%
Overall	85.3%

This highlights the discrepancies between specialties, and the often informal networks upon which they depend. From our visits to units, we discovered that this access to specialties frequently relied on personal relationships with specialist clinicians at tertiary centres rather than formal understandings between units.

> *"The regional unit are very helpful once you make contact but you don't get them immediately. I think they could do with more support to develop a more formal system."*

Whilst some were well served, others were not. It is particularly concerning that somewhere close to 10% of units did not feel that they had access to immediate intensive care advice. Similarly, almost a quarter of units did not feel they could contact an expert in respiratory medicine or gastroenterology, hepatology and nutrition immediately. Many of these networks of expertise are not formalised, resulting in a system that is reliant on a who-knows-who culture rather than homogenous and comprehensive arrangements. *Facing the Future* makes the point that this standard should ideally be met through managed clinical networks for specialties. This is work that the Strategic Clinical Networks for Children and Maternity in England should make an urgent priority, to reduce the unwarranted variation in care that may well result from such arrangements. Equally, in the other three home nations health trusts will need to work together to ensure that specialty advice is consistently accessible.

The final standard of *Facing the Future* is concerned with the implementation of robust child protection systems that are accessible for all agencies, around the clock. The College published *Safeguarding in 2012: views from the frontline*, which looked at the impact that NHS changes in the last couple of years have had on child protection issues from the perspective of named and designated doctors. While that report painted a gloomy picture of a system disrupted by reforms and lack of clarity over roles and responsibilities in the new system, the responses to standard 10 across the UK are more encouraging. Child protection arrangements in most hospitals are robust, comprehensive and closely integrated with social services, the police and other non-health agencies.

Nonetheless, there are an handful of hospitals in the UK where this is not the case, with 5.1% of English units not providing the same level of advice out of hours as they do during 9am to 5pm (see Appendix 2 for full results). This indicates that case decisions are being made either without appropriate paediatric involvement or are being delayed until the next working day, which could be compromising clinical care. Access to Child Sexual Abuse (CSA) services in the evening and night-time also appeared to be problematic in a couple of instances.

In two of the cases where hospitals admitted to not having adequate competency in child protection matters, our unit visits were a spur for those units to review their training and make the necessary adjustments to meet the standards.

The evidence that we received appears to suggest that Scotland may have a particular problem, with three out of seven responding units disclosing that the paediatricians that provide child protection advice don't have at least Level 3 of the intercollegiate safeguarding competencies. This risks inappropriate decision-making and could have serious potential implications, such as children not being referred to social care where they are at risk of harm. The RCPCH has already had discussions with the Scottish Government on these issues, and will be following up with the units concerned to ensure that there are adequate child protection arrangements across the UK.

It should be noted that this audit did not include standards contained in the explanatory text accompanying standard 10, only those contained in the substantive standard.

Conclusion

When the College published *Facing the Future* in April 2011, we could not have hoped for the impact that the standards have manifestly had on the service since that date. They have won the hearts and minds of paediatricians, and are being used on a daily basis by them both to reflect on their own practice and also to advocate for better care with their colleagues in hospital management and in clinical commissioning groups. It is a credit to the diligence and dedication of the paediatricians, nurses and other health professionals who work to deliver high quality care for children and young people that most of the time, most of the standards are being met across the UK.

Nonetheless, in the pursuit of excellence across the country, most of the standards, most of the time is not enough. This audit has highlighted that these standards are not being met as regularly at weekends and evenings as they are between the hours of 9am and 5pm. At times of peak activity, when you would expect the standard of service to be at its most robust, the most senior, skilled and experienced staff are not always present. It is essential that paediatrics is a 24 hours a day, 7 days a week specialty, and consequently the service should be organised around the child's needs. This will require careful job planning, but the principles outlined in *RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital* are paramount, and its echo of the Medical Schools Council, Consensus Statement on The Role of the Doctor; that 'the role of the doctor must be defined by what is in the best interests of the patients and the population served'[20].

On some of our unit visits we discovered strong support for the standards masking an attitude that they could pick and choose which ones were met or concentrated upon. Furthermore, the service is occasionally dependent on informal working relationships rather than robust, standardised network arrangements. These informal relationships and the hard work of many paediatricians in making things work in adverse conditions also masks the need for urgent reconfiguration of services, to ensure that paediatric services continue to provide the highest quality standards of care, and that children and young people are treated in the right place at the right time.

This informality unfortunately appears to extend to arrangements for data collection. One of the objectives of the audit was to assess whether data is being collected that demonstrates the quantitative impact that *Facing the Future* standards are having upon outcomes. The successful implementation of *Facing the Future* appears in some instances to have had the unintended consequence of discouraging the measuring of outcomes or self-auditing against the standards. As we have stated, there is an irony that those units which do not meet the standards for whatever reasons, have taken the initiative to ensure that their service is safe and sustainable by implementing robust audit and data collection programmes. It is essential that in those units where the standards are being met, this good practice is mirrored.

Back to Facing the Future highlights many areas clinical directors and paediatricians can reflect upon in order to continually improve the quality and safety of the service that they provide to meet the standards and more importantly ensure that children and young people receive the best possible care. Clearly there is also more work for the College to do in ensuring that the standards are met, but also following up on the implications of this report. As we reported when we first modelled the *Facing the Future* standards, there is no way in which the standards can be met with the current workforce, and with the current number of inpatient units. Children's health services cannot continue in their present form indefinitely. We will continue to look at more innovative models of service provision, providing more care in the community, whilst centralising expertise. The next stage of the *Facing the Future* project will look at developing these models, and how the standards impact on services across the local health economy. Two years is a long time in the NHS, and the next two will be particularly long. The College is committed to supporting it to face the future and ensure that children and young people receive the highest possible standards and outcomes of care.

[20] RCPCH (2009) *RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital*

Appendix 1

Methodology

The audit was carried out over the summer and autumn of 2012 in two stages. The first stage was a survey of all UK acute paediatric units which consisted of a questionnaire and a retrospective case note audit. The second stage consisted of a series of site visits and in-depth interviews with clinical directors, trainees and nurse/ward managers.

Units with acute paediatric services were identified using the results of the RCPCH Medical Workforce Census 2009[21]. Prior to conducting the survey, all clinical directors and their corresponding trust chief executives were contacted so that they were aware of the College's intentions and asked to provide up to date contact details if required.

The SurveyMonkey® survey (Appendix 1.1) consisted of 32 questions designed to assess compliance with standards 3 to 10. Throughout the questionnaire, respondents were given the opportunity to comment on the standards, and at the end they were asked to provide feedback on the structure of the survey and the standards themselves. The results of the survey were cleaned and analysed using Access and Excel, and are included in Appendix 2 – survey results. Comments and feedback were used to inform the contents of the report, and feedback on the survey itself will be used to inform future data collection activities. Additional data from the RCPCH Medical Workforce Census and Rota Compliance and Vacancies Survey were used to report on compliance with standard eight where respondents chose not to provide data themselves.

It should be noted that in the questionnaire respondents were self-reporting on compliance and were not required to provide evidence to back up their responses.

The retrospective case note audit of 20 acute paediatric admissions was used to assess compliance with standards one and two. Units were provided with a custom spreadsheet tool, which in the majority of cases were completed by trainees. Respondents were asked to look at 20 sets of case notes from 1 March 2012 onwards, with at least half of the cases being admitted outside 9-5pm. For the purposes of the audit, an admission was defined as an admission to the paediatric department or paediatric assessment unit and not attendance at the emergency department. Cases were able to meet standard one if a child was seen in the emergency department prior to admission by a middle grade or consultant paediatrician.

For each case, respondents were asked for the following:

- Date and time of admission
- Date and time first seen by a paediatrician on the middle grade or consultant rota
- Whether that person was an ST3 on the middle grade
- Date and time first seen by a consultant paediatrician (or equivalent)
- Date and time of discharge
- Outcome
- Any relevant comments or details of non-standard arrangements

These data were used to calculate compliance with standards one and two, and overall percentage compliance was calculated for each unit.

It should be noted that although 20 case notes were asked for, not all calculations of compliance were based on this number of admissions due to missing data, or admissions included that were less than the four and 24 hour thresholds.

[21] RCPCH (2009) *Medical Workforce Census 2009. http://www.rcpch.ac.uk/system/files/protected/page/RCPCH_WC_2009_txt.pdf*

Data from the survey and case note audit were analysed by country, unit size and trust type (tertiary, acute, and with our without community services). Unit size was determined using 2011 to 2012 admission data. Admissions include those emergencies admitted via the A&E, via the GP, via Bed Bureau, via consultant outpatient clinic and via other means, including via the A&E department of another hospital. Units were classified very small, small, medium and large according to the thresholds given in Table 9.

Table 9: Unit size classifications based on admissions per year

Unit size classification	Admissions per year
Very small	<1500
Small	1501 to 2500
Medium	2501 to 5000
Large	>5000

The second stage of the audit was a series of visits to 14 units across England, Northern Ireland, Scotland and Wales. Sites were selected, to give a geographical and unit size spread, and based on interesting comments or innovative models mentioned in the initial survey. These visits involved a series of structured interviews, typically with the clinical lead; nurse or ward manager; and up to two trainee paediatricians. The majority were conducted at the hospital; however a couple were completed via teleconference where it was not possible to travel or availability of those involved was limited.

Clinical directors were asked about their compliance with each standard as well as a set of general questions. Trainees and nurse/ward managers were asked more general questions about the standards and attitudes toward them. The full interview questions are available in Appendix 1.2. The results of the interviews have been used to inform the report, however full transcripts have not been included to protect the anonymity of the sites involved.

Appendix 1.1: Data collection part 1 – Survey and case note audit

Standards 1 and 2

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

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

In order to monitor standards 1 and 2, we require you to assess 20 acute paediatric admissions retrospectively. You will need to record time of registration, time first seen by a doctor (and their grade), time first seen by a consultant and time of discharge.

Please download the Excel spreadsheet using the link below and save it on your computer, renaming it with your trust name.

Once you have completed the spreadsheet, please email it to facingthefuture@rcpch.ac.uk
You may wish to delegate the auditing of standards 1 and 2 to another member of staff. If so please pass on the spreadsheet to that member of staff. You may continue to answer the survey questions in the meantime.

Standard 3

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

Please answer the following questions in relation to Standard 3:

1. Does your rota structure allow every child or young person with an acute medical problem who is referred for a paediatric opinion to be seen by, or have their case discussed with a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner?

- Yes
- No

2. In practice, does every child or young person with an acute medical problem who is referred for a paediatric opinion get seen by, or have their case discussed with a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner?

- Yes
- No

3. Why is it not possible to meet Standard 3 in your trust?

Free text

4. Please use the box below to record any comments you may have regarding Standard 3 and your answers to the questions relating to it.

Free text

Standard 4

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

A SSPAU is defined as a facility within which children with acute illness, injuries or other urgent referrals (from GPs, Community Nursing teams, Walk in Centres, NHS Direct, EDs) can be assessed, investigated, observed and treated without recourse to inpatient areas.

Source: Short Stay Paediatric Assessment Units Advice for Commissioners and Providers
**As defined in standard 2.*

Please answer the following questions relating to Standard 4:

5. Do you have a Short Stay Paediatric Assessment Unit (SSPAU)?

- Yes
- No

6. Between which hours is your SSPAU open?

Opening time:
Closing time:

7. Does the SSPAU have access to a paediatric consultant (or equivalent) opinion throughout all the hours it is open?

- Yes, in person
- Yes, by telephone
- No

8. Is it a standalone SSPAU?

- Yes
- No

A standalone SSPAU is not co-located with a paediatric inpatient ward or with the emergency department.

9. Please use the box below to record any comments you may have regarding Standard 4 and your answers to the questions relating to it.

Free text

Standard 5

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

Please answer the following question relating to Standard 5:

10. How often is your medical handover led by a paediatric consultant (or equivalent)?

- Two or more times a day on weekdays and weekends
- Two or more times a day on weekdays but not at weekends
- Once a day on weekdays and weekends
- Once a day on weekdays but not at weekends
- Less than once a day
- Less than once a week
- Never

11. Please use the box below to record any comments you may have regarding Standard 5 and your answers to the questions relating to it.

Free text

Standard 6

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

Please answer the following questions relating to Standard 6:

12. What do you consider are your typical peak hours of activity?

	Start of peak time	End of peak time
On weekdays		
At weekends		

13. On weekdays, at what times is there a consultant (or equivalent) present?

- 24 hours a day
- 09:00 to 21:00
- 09:00 to 17:00
- Other (please specify)

14. At weekends, at what times is there a consultant (or equivalent) present?

- 24 hours a day
- 09:00 to 21:00
- 09:00 to 17:00
- Other (please specify)

15. Please use the box below to record any comments you may have regarding Standard 6 and your answers to the questions relating to it.

Free text

Standard 7

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

The attending consultant system is also known as 'paediatrician of the week', 'neonatologist of the week', or 'hot week' and can be defined as one in which the consultant has no other clinical duties that week but is fully available for the management of acute admissions.

Source: RCPCH Medical Workforce Census 2009

Please answer the following questions relating to Standard 7:

16. Do you have a consultant of the week (or hot week) system in operation?

- Yes
- No

17. From Monday 23 July 2012 to Sunday 29 July 2012, was the consultant of the week system implemented?

- Yes, fully
- Yes, partially
- No

18. Please use the box below to record any comments you may have regarding Standard 7 and your answers to the questions relating to it.

Free text

Standard 8

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

The College has data from the RCPCH workforce census 2011 and the Rota Vacancies and Compliance Survey 2011-2012 which can be used to assess this standard. Please indicate below whether you are happy for us to do this or whether you would like to provide up to date information.

19. How would you like us to assess standard 8?

- I am happy for you to use data already collected
- I would like to provide the data again

20. Rota WTE and compliance

Please enter the number of whole (full) time equivalent doctors working on each rota (including gaps due to sickness, maternity leave or out of programme) and whether or not they are compliant with EWTR on paper and in practice. If any of these rotas do not exist within the trust, please leave them blank.

	Whole time equivalent	Compliant on paper	Compliant in practice
Tier 1 general			
Tier 1 general/ neonatal			
Tier 2 general			
Tier 2 general/ neonatal			
Tier 3 general			
Tier 3 general/ neonatal			

21. Please use the following box to record any comments you may have about Standard 8.

Standard 9

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

Please answer the following question relating to Standard 9:
NOTE: This standard does not apply when the presenting problem is not an emergency, nor does it apply to referrals from non-paediatricians who should, in the first instance, seek the advice of their local paediatric service.

22. Please select the subspecialties where there is a Specialist Paediatrician available to all paediatricians for immediate telephone advice for acute problems: This telephone advice can be available within the trust or through a network.

- Gastroenterology, hepatology and nutrition
- Endochrinology
- Oncology
- Respiratory Medicine
- Intensive Care Medicine
- Nephrology
- Paediatric Cardiology
- Neurology

23. Please use the box below to record any comments you may have regarding Standard 9 and your answers to the question relating to it.

Free text

Standard 10

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

Please answer the following question relating to Standard 10. If you are unable to answer this question yourself please consult your named or designated doctor for safeguarding.

24. Do all health teams have access to a paediatrician for child protection advice?

- Yes
- No

25. Do all those paediatricians have child protection expertise to at least Level 3 of the intercollegiate safeguarding competences?

- Yes
- No

26. At what times are those paediatricians available?

- 24 hours a day, 7 days a week
- 09:00 to 21:00
- 09:00 to 17:00
- Other (please specify)

27. Are those paediatricians available for both advice and assessment (including provision of medical opinions and reports)?

- Advice only
- Advice and assessment

28. Are those paediatricians available to other non-health agencies?

- Yes
- No

29. Please use the box below to record any comments you may have regarding Standard 10 and your answers to the question relating to it.

Free text

Follow up

30. We would like to take a more in-depth look at adherence to *Facing the Future* standards and the practicalities of their implementation by carrying out visits to a selection of units. Would you be happy to take part in a follow up visit?

- Yes
- No

Thank you for completing these questions. Please remember to return the spreadsheet covering Standards 1-2 to facingthefuture@rcpch.ac.uk

Please use the following boxes to provide your comments on the standards and on this survey.

31. Please use the following box to provide any additional comments you have about the Facing the Future standards:

Free text

32. Please use the following box to provide feedback about this survey and the structure of the audit:

Free text

Appendix 1.2: Interview questions

Visit interview questions – Clinical Director

Standards 1-10

If standard MET:

1. How have you ensured you can meet this standard?

2. For how long have you been able to meet this standard?

3. Do you have any evidence that meeting the standard is improving quality and outcomes?

4. Is your ability to meet this standard sustainable?

If standard NOT MET:

5. Why are you not able to meet this standard?

6. Do you feel that not meeting this standard affects quality and outcomes?

7. Have you got any provision in place to work towards meeting this standard?

General questions

8. Is the trust part of a network arrangement in which staff provide a service on more than one site?

9. Were you aware of *Facing the Future* standards before starting this audit?

10. On a scale of 1 to 5, with 1 being very easy and 5 not at all easy, how easy do you find it to understand the standards?

11. On a scale of 1 to 5, with 1 being very easy, and 5 not at all easy, how easy do you find it to meet the standards?

12. Do the standards form part of the Trust's service improvement/audit or governance plans?

13. Are these standards useful in benchmarking service provision?

14. Are commissioners in your area aware of these standards?

15. Have you used the standards in discussions with commissioners and managers?

16. If yes, have they been useful?

17. How do you intend to use the feedback from this audit?

18. Is there any further advice, guidance or work in this area that would be useful to you?

19. Additional comments

Visit interview questions – Trainee

1. How long have you been working at this unit?

2. What stage are you at in your training?

3. Were you aware of *Facing the Future* standards before starting this audit?

4. If yes, how did you become aware of the document?

5. Have you experienced or do you anticipate additional pressures on your workload as a result of *Facing the Future* standards?

5.1 If yes, what do you anticipate these additional pressures to be/what are the additional pressures?

6. Do you feel *Facing the Future* standards have helped or hindered your training?

7. In what way have they helped or hindered your training?

8. Has your knowledge of *Facing the Future* standards changed your clinical practice?

8.1. If yes, in what way has it changed?

9. Do you have any specific examples of instances when a standard was not met?

9.1 If yes, standard:

Description:

10. In your trust, which standards do you think are most difficult to achieve?

11. Do you perceive that your seniors are generally positive or negative towards the standards?

12. Additional comments

Visit interview questions – Nurse or ward manager

1. Were you aware of *Facing the Future* standards before starting this audit?

1.1 If you were aware, have you made your nursing staff aware of these standards?

2. Do you feel you can easily contact an SHO during peak times?

3. Do you feel you can easily contact an SpR during peak times?

4. If you are unable to contact an SHO or SpR, do you feel you can easily contact a consultant?

5. Is there a lead nurse included in the handover?

6. Are general nursing staff included in the handover?

7. Do you feel that there is a paediatric consultant present during times of peak activity?

8. Have you experienced or do you anticipate additional pressures on your workload as a result of *Facing the Future* standards?

8.1 If yes, what do you anticipate these additional pressures to be/what are the additional pressures?

9. Do you feel these standards have improved the quality of care, or have the potential to?

10. Additional comments

Appendix 2: Survey results

This section provides a detailed analysis of the results obtained in the case note audit and questionnaire which has not already been provided in the main report. Where appropriate, responses have been analysed according to country, trust type and unit size. Given the small number of responses from Northern Ireland, Scotland and Wales, those nations have been grouped together. Unit size is based on number of admissions in the year 2011-2012. More information about the methodology applied can be found in *Appendix 1 - Methodology*.

Response rate

Table 10: Response rate to survey and case note audit

Total units contacted	174	
Total responded overall	121	
Overall response rate		**69.5%**
Total responded case note audit	106	
Case note audit response rate		**60.9%**

Standard 1

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

Data used to analyse compliance with standard 1 was taken from the case note audit of 20 retrospective cases provided by 106 units. In total 1970 admissions were recorded, although not all information was complete for all cases

Table 11: Average compliance with standard 1 by country

Country	% compliance	Total respondents
England	77.3%	96
NI, Scotland and Wales	77.0%	10
Overall	**77.4%**	**106**

Table 12: Average compliance with standard 1 by trust type

Trust type	% compliance	Total respondents
Acute	81.4%	31
Acute and community	76.1%	58
Tertiary and acute	80.9%	8
Tertiary, acute and community	68.9%	9
Overall	**77.4%**	**106**

Table 13: Average compliance with standard 1 by unit size

	% compliance	Total respondents
Very small	83.0%	5
Small	79.0%	22
Medium	75.4%	56
Large	79.0%	22
Overall	**77.4%**	**105**

Table 14: Compliance with standard 1 by weekday/weekend admission

	Met	Not met	Total
Weekday	1063	280	1343
	79.2%	*20.8%*	*100.0%*
Weekend	361	131	492
	73.4%	*26.6%*	*100.0%*
Overall	**1424**	**411**	**1835***
	77.6%	*22.4%*	*100.0%*

*135 cases did not provide all the information required to analyse compliance

Table 15: Compliance with standard 1 by time of day admitted

	Met	Not met	Total
Day	609	148	757
	80.4%	*19.6%*	*100.0%*
Evening	467	116	583
	80.1%	*19.9%*	*100.0%*
Night	338	146	484
	69.8%	*30.2%*	*100.0%*
Overall	**1414**	**410**	**1824***
	77.5%	*22.5%*	*100.0%*

*146 cases did not provide all the information required to analyse compliance

Day time admissions are those admitted between 09:00 and 16:59, evening admissions are those admitted between 17:00 and 21:59 and night admissions those admitted between 22:00 and 08:59.

Standard 2

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

Data used to analyse compliance with standard 1 was taken from the case note audit of 20 retrospective cases provided by 106 units. In total, information about 1835 admissions was provided, although some of these were less than 24 hours so did not trigger standard 2.

Table 16: Average compliance with standard 2 by country

	% compliance	Total respondents
England	88.2%	96
NI, Scotland and Wales	83.0%	10
Overall	**87.7%**	**106**

Table 17: Average compliance with standard 2 by trust type

	% compliance	Number of trusts
Acute	89.3%	31
Acute and community	88.0%	58
Tertiary and acute	85.9%	8
Tertiary, acute and community	81.9%	9
Overall	**87.7%**	**106**

Table 18: Average compliance with standard 2 by unit size

	% compliance	Total respondents
Very small	93.4%	5
Small	88.0%	22
Medium	86.4%	56
Large	88.8%	22
Overall	**87.7%**	**105***

*Size data not available for 1 unit

Table 19: Compliance with standard 2 by weekday/weekend admission

	Met	Not met	Total
Weekday	895	112	1007
	88.9%	*11.1%*	*100.0%*
Weekend	317	56	373
	85.0%	*15.0%*	*100.0%*
Overall	**1212**	**168**	**1380***
	87.8%	*12.2%*	*100.0%*

*590 cases were either less than 24 hours or did not provide all the information required to analyse compliance

Table 20: Compliance with standard 2 by time of day admitted

	Met	Not met	Total
Day	471	75	546
	86.3%	*13.7%*	*100.0%*
Evening	399	37	436
	91.5%	*8.5%*	*100.0%*
Night	333	56	389
	85.6%	*14.4%*	*100.0%*
Overall	**1203**	**168**	**1371***
	87.7%	*12.3%*	*100.0%*

*599 cases were either less than 24 hours or did not provide all the information required to analyse compliance

Day time admissions are those admitted between 09:00 and 16:59, evening admissions are those admitted between 17:00 and 21:59 and night admissions those admitted between 22:00 and 08:59.

Table 21: Admissions seen by ST3 doctor on the middle grade by time admitted

	Seen by ST3 doctor	Seen by ST4 and above	Total
Day	218	558	776
	28%	*72%*	*100%*
Evening	166	439	605
	27%	*73%*	*100%*
Night	133	339	472
	28%	*72%*	*100%*
Not known	4	13	17
	24%	*76%*	*100%*
Overall	**521**	**1349**	**1870**
	28%	*72%*	*100%*

*100 cases did not indicate whether or not they were first seen by an ST3 doctor on middle grade

Table 22: Admissions first seen by ST3 doctor subsequently seen by consultant within 12 hours

	Seen within 12 hours	Not seen within 12 hours	Admission < 12 hours	Unknown (time or date missing)	Total
Day	44	94	67	13	218
	20%	*43%*	*31%*	*6%*	*100%*
Evening	22	91	37	16	166
	13%	*55%*	*22%*	*10%*	*100%*
Night	72	33	17	11	133
	54%	*25%*	*13%*	*8%*	*100%*
Overall	**138**	**218**	**121**	**40**	**517***
	27%	*42%*	*23%*	*8%*	*100%*

*4 cases seen by ST3 doctors did not give a time of admission

Table 23: Admissions first seen by ST4 and above (or equivalent) subsequently seen by consultant within 12 hours

	Seen by consultant within 12 hours	Not seen by consultant within 12 hours	Admission < 12 hours	Unknown (time or date missing)	Total
Day	169	224	122	43	558
	30%	*40%*	*22%*	*8%*	*100%*
Evening	84	222	90	43	439
	19%	*51%*	*21%*	*10%*	*100%*
Night	203	70	50	16	339
	60%	*21%*	*15%*	*5%*	*100%*
Overall	**456**	**516**	**262**	**102**	**1336***
	34%	*39%*	*20%*	*8%*	*100%*

*13 cases did not give a time of admission

Table 24: All admissions seen by consultant within 12 hours

	Seen by consultant within 12 hours	Not seen by consultant within 12 hours	Admission < 12 hours	Unknown (date or time missing)	Total
Day	213	330	212	61	816
	26%	*40%*	*26%*	*7%*	*100%*
Evening	109	323	138	62	632
	17%	*51%*	*22%*	*10%*	*100%*
Night	287	108	73	34	502
	57%	*22%*	*15%*	*7%*	*100%*
Overall	**609**	**761**	**423**	**157**	**1950***
	31%	*39%*	*22%*	*8%*	*100%*

*20 cases did not give a time of admission

Standard 3

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

Table 25: Compliance with standard 3 in theory

	Yes	No	Total
England	107	1	108
	99.1%	*0.9%*	*100.0%*
NI, Scotland and Wales	13	0	13
	100.0%	*0.0%*	*100.0%*
Overall	**120**	**1**	**121**
	99.2%	*0.8%*	*100.0%*

Table 26: Compliance with standard 3 in practice

	Yes	No	Total
England	104	4	108
	96.3%	*3.7%*	*100.0%*
NI, Scotland and Wales	11	1	12
	91.7%	*8.3%*	*100.0%*
Overall	**115**	**5**	**120**
	95.8%	*4.2%*	*100.0%*

Standard 4

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

Table 27: Units with SSPAUs

	Yes	No	Total
England	79	28	107
	73.8%	*26.2%*	*100.0%*
NI, Scotland and Wales	13	0	13
	100.0%	*0.0%*	*100.0%*
Overall	**92**	**29**	**121**
	77.3%	*24.4%*	*100.0%*

Table 28: Compliance with standard 4

	Yes, in person	Yes, by telephone	No	Total
England	33	46	0	79
	41.8%	*58.2%*	*0.0%*	*100.0%*
NI, Scotland and Wales	7	5	1	12
	58.3%	*41.6%*	*0.0%*	*100.0%*
Overall	**40**	**51**	**1**	**92**
	43.5%	*55.4%*	*1.1%*	*100.0%*

Table 29: Compliance with standard 4 by trust type

	Yes, in person	Yes, by telephone	No	Total
Acute	14	14	0	28
	50%	*50%*	*0%*	
Acute and community	21	30	1	52
	40%	*58%*	*2%*	
Tertiary and acute	1	3	0	4
	25%	*75%*	*0%*	
Tertiary, acute and community	3	4	0	7
	43%	*57%*	*0%*	
Overall	**40**	**51**	**1**	**92**
	43%	*55%*	*1%*	*100%*

Table 30: Compliance with standard 4 by unit size

	Yes, in person	Yes, by telephone	No	Total
Very small	2	0	0	2
	100.0%	*0.0%*	*0.0%*	*100.0%*
Small	6	8	0	14
	42.9%	*57.1%*	*0.0%*	*100.0%*
Medium	25	25	1	51
	49.0%	*49.0%*	*2.0%*	*100.0%*
Large	7	17	0	24
	29.2%	*70.8%*	*0.0%*	*100.0%*
Size not available	0	1	0	1
	0.0%	*100.0%*	*0.0%*	*100.0%*
Total	**40**	**51**	**1**	**92**
	43.5%	*55.4%*	*1.1%*	*100.0%*

Standard 5

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

Table 31: Compliance with standard 5

	Handover led by consultant (or equivalent) at least once a day	Handover led by consultant (or equivalent) less than once a day	Total
England	100	6	106
	94.3%	*5.7%*	*100.0%*
NI, Scotland and Wales	12	1	13
	92.3%	*7.7%*	*100.0%*
Overall	**112**	**7**	**119***
	94.1%	*5.9%*	*100.0%*

*2 units did not respond to this question

Table 32: Compliance with standard 5 by trust type

	Handover led by consultant (or equivalent) at least once a day	Handover led by consultant (or equivalent less than once a day	Total
Acute	36	0	36
	100.0%	*0.0%*	*100.0%*
Acute and community	59	6	65
	90.8%	*9.2%*	*100.0%*
Tertiary and acute	7	0	7
	100.0%	*0.0%*	*100.0%*
Tertiary, acute and community	10	1	11
	90.9%	*9.1%*	*100.0%*
Overall	**112**	**7**	**119***
	94.1%	*5.9%*	*100.0%*

*2 units did not respond to this question

Table 33: Compliance with standard 5 by unit size

	Handover led by consultant (or equivalent) at least once a day	Handover led by consultant (or equivalent less than once a day	Total
Very small	5	2	7
	71.4%	*28.6%*	*100.0%*
Small	24	2	26
	92.3%	*7.7%*	*100.0%*
Medium	56	3	59
	94.9%	*5.1%*	*100.0%*
Large	26	0	26
	100.0%	*0.0%*	*100.0%*
Size not available	1	0	1
	100.0%	*0.0%*	*100.0%*
Overall	**112**	**7**	**119***
	94.1%	*5.9%*	*100.0%*

*2 units did not respond to this question

Standard 6

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

In *Facing the Future*, peak activity times were defined as 5-10pm in the evening. In this audit, units were asked to define their own peak times (see Table 34 and Table 39). Consultant presence was matched to both College defined peak times and self-defined peak hours. Units were only considered compliance if they had consultant presence throughout the entire peak period, and not part coverage.

Table 34: Consultant presence during College defined peak hours (5-10pm) on weekdays

	Yes	No	Not known	Total
England	12	84	8	104
	12%	*81%*	*8%*	*100%*
NI, Scotland and Wales	1	12	0	13
	7.7%	*92.3%*	*0.0%*	*100%*
Overall	**13**	**96**	**8**	**117***
	11%	*82%*	*7%*	*100%*

*4 units did not provide data

Table 35: Consultant presence during College defined peak hours on weekdays, by unit size

	Yes	No	Not known	Total
Very small	1	6	0	7
	14.3%	*85.7%*	*0.0%*	*100.0%*
Small	4	18	3	25
	16.0%	*72.0%*	*12.0%*	*100.0%*
Medium	6	48	4	58
	10.3%	*82.8%*	*6.9%*	*100.0%*
Large	2	23	1	26
	7.7%	*88.5%*	*3.8%*	*100.0%*
Size not available	0	1	0	1
	0%	*100%*	*0%*	*100%*
Total	**13**	**96**	**8**	**117**
	11.1%	*82.1%*	*6.8%*	*100.0%*

*4 units did not provide data

Table 36: Self-identified weekday peak periods

	Number of units	%
Morning	1	0.9%
All day	11	9.6%
All day and evening	23	20.2%
Afternoon	10	8.8%
Afternoon and evening	59	51.8%
Evening	10	8.8%
Total	**114***	**100.0%**

*7 units did not provide data

Table 37: Consultant presence during self-identified peak periods on weekdays

	Yes	No	Not known	Total
England	27	66	11	104
	26%	*63%*	*11%*	*100%*
NI, Scotland and Wales	3	10	0	13
	23.1%	*76.9%*	*0%*	*100%*
Overall	**30**	**76**	**11**	**117***
	26%	*65%*	*9%*	*100%*

*4 units did not provide data

Table 38: Consultant presence during self-identified peak periods on weekdays by unit size

	Yes	No	Not known	Total
Very small	2	5	0	7
	28.6%	*71.4%*	*0.0%*	*100.0%*
Small	9	13	3	25
	36.0%	*52.0%*	*12.0%*	*100.0%*
Medium	12	40	6	58
	20.7%	*69.0%*	*10.3%*	*100.0%*
Large	7	17	2	26
	26.9%	*65.4%*	*7.7%*	*100.0%*
Size not available	0	1	0	1
	0.0%	*100.0%*	*0.0%*	*100.0%*
Overall	**30**	**76**	**11**	**117**
	25.6%	*65.0%*	*9.4%*	*100.0%*

Table 39: Consultant presence during College defined peak hours (5-10pm) at weekends

	Yes	No	Not known	Total
England	6	96	2	104
	6%	*92%*	*2%*	*100%*
NI, Scotland and Wales	1	11	1	13
	7.7%	*84.6%*	*7.7%*	*100%*
Overall	**7**	**107**	**3**	**117***
	6%	*91%*	*3%*	*100%*

*4 units did not provide data

Table 40: Consultant presence during College defined peak hours at weekends by unit size

	Yes	No	Not known	Total
Very small	1	6	0	7
	14.3%	*85.7%*	*0.0%*	*100.0%*
Small	1	23	1	25
	4.0%	*92.0%*	*4.0%*	*100.0%*
Medium	4	54	0	58
	93.1%	*93.1%*	*0.0%*	*100.0%*
Large	1	23	2	26
	3.8%	*88.5%*	*7.7%*	*100.0%*
Size not available	0	1	0	1
	0%	*100%*	*0%*	*100%*
Overall	**7**	**107**	**3**	**117***
	6.0%	*91.5%*	*2.6%*	*100.0%*

*4 units did not provide data

Table 41: Self-identified weekend peak periods

	Number of units	%
Morning	20	18.5%
All day	8	7.4%
All day and evening	24	22.2%
Afternoon	15	13.9%
Afternoon and evening	28	25.9%
Evening	13	12.0%
Total	**108***	**100.0%**

*13 units did not provide data

Table 42: Consultant presence during self-identified peak periods at weekends

	Yes	No	Not known	Total
England	21	72	11	104
	20%	*69%*	*11%*	*100%*
NI, Scotland and Wales	2	9	2	13
	15.4%	*69.2%*	*15.4%*	*100%*
Overall	**23**	**81**	**13**	**117***
	20%	*69%*	*11%*	*100%*

*4 units did not provide data

Table 43: Consultant presence during self-identified peak periods at weekends by unit size

	Yes	No	Not known	Total
Very small	2	5	0	7
	28.6%	*71.4%*	*0.0%*	*100.0%*
Small	6	16	3	25
	24.0%	*64.0%*	*12.0%*	*100.0%*
Medium	10	43	5	58
	17.2%	*74.1%*	*8.6%*	*100.0%*
Large	5	16	5	26
	19.2%	*61.5%*	*19.2%*	*100.0%*
Size not available	0	1	0	1
	0.0%	*100.0%*	*0.0%*	*100.0%*
Overall	**23**	**81**	**13**	**117***
	19.7%	*69.2%*	*11.1%*	*100.0%*

*4 units did not provide data

Standard 7

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

Table 44: Units with consultant of the week (or equivalent) in place

	Yes	No	Total
England	98	9	107
	91.6%	*8.4%*	*100.0%*
NI, Scotland and Wales	12	1	13
	92.3%	*7.7%*	*100.0%*
Overall	**110**	**10**	**120***
	92.4%	*8.4%*	*100.0%*

*1 unit did not provide data

Table 45: Units with consultant of the week (or equivalent) in place by size

	Yes	No	Total
Very small	6	1	7
	85.7%	*14.3%*	*100.0%*
Small	24	2	26
	92.3%	*7.7%*	*100.0%*
Medium	54	5	59
	91.5%	*8.5%*	*100.0%*
Large	25	2	27
	92.6%	*7.4%*	*100.0%*
Size not available	1	0	1
	100.0%	*0.0%*	*100.0%*
Total	**110**	**10**	**120***
	91.7%	*8.3%*	*100.0%*

*1 unit did not provide data

Table 46: Was the consultant of the week system implemented between 23/7/12 and 29/7/12?

	Yes, fully	Yes, partially	No	Total
England	93	3	0	96
	96.9%	*3.1%*	*0.0%*	*100.0%*
NI, Scotland and Wales	12	0	0	12
	100.0%	0.0%	0.0%	100.0%
Overall	**105**	**3**	**0**	**108***
	97.2%	*2.8%*	*0.0%*	*100.0%*

*2 units did not provide data

Standard 8

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

Table 47: Compliance by rota tier

	Less than 10 on rota	10 or more on rota	Total
Tier 1	82	35	117
	70%	*30%*	*100%*
Tier 2	76	35	111
	68%	*32%*	*100%*
Tier 3	83	22	105
	79%	*21%*	*100%*
Overall count	**241**	**92**	**333***
	72%	*28%*	*100%*

*Note rota numbers were not available for all units

Table 48: Average WTE by rota type and tier

Rota type	Tier 1	Tier 2	Tier 3
General	9.4	9.8	7.9
General/neonatal	9.1	8.3	7.7

*Note rota numbers were not available for all units

Table 49: Average WTE by country and tier

Country	Tier 1	Tier 2	Tier 3
England	9.2	9.0	7.6
NI, Scotland and Wales	9.4	8.2	9.0
Overall average	**9.3**	**8.9**	**7.8**

*Note rota numbers were not available for all units

Table 50: Average WTE by unit size and tier

	Tier 1	Tier 2	Tier 3
Very small	9.0	6.7	7.5
Small	7.5	8.5	7.1
Medium	9.5	8.6	7.4
Large	10.6	10.1	8.4
Overall	**9.3**	**8.9**	**7.8**

Table 51: Compliance with European Working Time Directive on paper

	Yes	No	Total
Tier 1	96	0	96
	100.0%	*0.0%*	*100.0%*
Tier 2	88	3	91
	96.7%	*3.3%*	*100.0%*
Tier 3*	8	3	11
	72.7%	*27.3%*	*100.0%*
Total	**192**	**6**	**198**
	97.0%	*3.0%*	*100.0%*

*Note compliance data not available for all

Table 52: Compliance with European Working Time Directive in practice

	Yes	No	Total
Tier 1	91	5	96
	94.8%	*5.2%*	*100.0%*
Tier 2	77	14	91
	84.6%	*15.4%*	*100.0%*
Tier 3	7	4	11
	63.6%	*36.4%*	*100.0%*
Overall	**175**	**23**	**198**
	88.4%	*11.6%*	*100.0%*

*Note compliance data not available for all

Standard 9

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

Units were asked about availability for immediate telephone advice for eight specialties, as below.

Table 53: Access to subspecialties by country

	Endocrinology	Gastroenterology, Hepatology and Nutrition	Intensive Care Medicine	Nephrology	Neurology	Oncology	Paediatric Cardiology	Respiratory Medicine	Respondents in country
England	86	84	97	95	91	97	97	84	108
	79.6%	*77.8%*	*89.8%*	*88.0%*	*84.3%*	*89.8%*	*89.8%*	*77.8%*	*100.0%*
NI, Scotland and Wales	8	9	13	13	13	13	13	9	13
	61.5%	*69.2%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*69.2%*	*100.0%*
Overall	**94**	**93**	**114**	**108**	**104**	**110**	**110**	**93**	**121**
	77.7%	*76.9%*	*94.1%*	*89.3%*	*86.0%*	*90.9%*	*90.9%*	*76.9%*	*100.0%*

Table 54: Access to subspecialties by trust type

	Endocrinology	Gastroenterology, Hepatology and Nutrition	Intensive Care Medicine	Nephrology	Neurology	Oncology	Paediatric Cardiology	Respiratory Medicine	Respondents
Acute	30	29	34	31	31	34	33	28	37
	81.1%	*78.4%*	*91.9%*	*83.8%*	*83.8%*	*91.9%*	*89.2%*	*75.7%*	*100.0%*
Acute and community	46	48	58	59	56	58	59	50	65
	70.8%	*73.8%*	*89.2%*	*90.8%*	*86.2%*	*89.2%*	*90.8%*	*76.9%*	*100.0%*
Tertiary and acute	7	6	7	7	6	7	7	6	8
	87.5%	*75.0%*	*87.5%*	*87.5%*	*75.0%*	*87.5%*	*87.5%*	*75.0%*	*100.0%*
Tertiary, acute and community	11	10	11	11	11	11	11	9	11
	100.0%	*90.9%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*81.8%*	*100.0%*
Overall	**94**	**93**	**110**	**108**	**104**	**110**	**110**	**93**	**121**
	77.7%	*76.9%*	*90.9%*	*89.3%*	*86.0%*	*90.9%*	*90.9%*	*76.9%*	*100.0%*

Table 55: Access to subspecialties by unit size

	Endochrinology	Gastroenterology, Hepatology and Nutrition	Intensive Care Medicine	Nephrology	Neurology	Oncology	Paediatric Cardiology	Respiratory Medicine	Respondents
Very small	5	6	7	7	7	7	7	5	7
	71.4%	*85.7%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*71.4%*	
Small	21	20	22	23	22	23	23	22	26
	80.8%	*76.9%*	*84.6%*	*88.5%*	*84.6%*	*88.5%*	*88.5%*	*84.6%*	
Medium	49	47	56	53	51	56	56	46	60
	81.7%	*78.3%*	*93.3%*	*88.3%*	*85.0%*	*93.3%*	*93.3%*	*76.7%*	
Large	18	19	24	24	23	23	23	19	27
	66.7%	*70.4%*	*88.9%*	*88.9%*	*85.2%*	*85.2%*	*85.2%*	*70.4%*	
Size not available	1	1	1	1	1	1	1	1	1
	100.0%	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	
Overall	**94**	**93**	**110**	**108**	**104**	**110**	**110**	**93**	**121**
	77.7%	*76.9%*	*90.9%*	*89.3%*	*86.0%*	*90.9%*	*90.9%*	*76.9%*	

Standard 10

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

Table 56: Access to a paediatrician for child protection advice by country

	Yes	No	Total
England	105	2	107
	98.1%	*1.9%*	*100.0%*
NI, Scotland and Wales	13	0	13
	100.0%	*0.0%*	*100.0%*
Overall	**118**	**2**	**120***
	98.3%	*1.7%*	*100.0%*

*1 unit did not provide data

Table 57: Access to a paediatrician for child protection advice by unit size

	Yes	No	Total
Very small	7	0	7
	100.0%	*0.0%*	*100.0%*
Small	26	0	26
	100.0%	*0.0%*	*100.0%*
Medium	59	0	59
	100.0%	*0.0%*	*100.0%*
Large	25	2	27
	92.6%	*7.4%*	*100.0%*
Size not available	1	0	1
	100.0%	*0.0%*	*100.0%*
Total	**118**	**2**	**120***
	98.3%	*1.7%*	*100.0%*

*1 unit did not provide data

Table 58: Do those paediatricians have at least Level 3 of the intercollegiate safeguarding competencies?

	Yes	No	Total
England	101	4	105
	96.2%	*3.8%*	*100.0%*
Northern Ireland	3	0	3
	100.0%	*0.0%*	*100.0%*
Scotland	4	3	7
	57.1%	*42.9%*	*100.0%*
Wales	3	0	3
	100.0%	*0.0%*	*100.0%*
Overall	**111**	**7**	**118**
	94.1%	*5.9%*	*100.0%*

Table 59: Availability of paediatricians with at least Level 3 competencies by unit size

	Yes	No	Total
Very small	6	1	7
	85.7%	*14.3%*	*100.0%*
Small	25	1	26
	96.2%	*3.8%*	*100.0%*
Medium	56	3	59
	94.9%	*5.1%*	*100.0%*
Large	23	2	25
	92.0%	*8.0%*	*100.0%*
Size not available	1	0	1
	100.0%	*0.0%*	*100.0%*
Overall	**111**	**7**	**118**
	94.1%	*5.9%*	*100.0%*

Table 60: Availability of paediatricians with Level 3 intercollegiate safeguarding competencies

	09:00 to 17:00	09:00 to 21:00	24 hours a day, 7 days a week	Total
England	5	0	93	98
	5.1%	*0.0%*	*94.9%*	*91.6%*
Northern Ireland	2	0	0	2
	100.0%	*0.0%*	*0.0%*	*100.0%*
Scotland	0	1	3	4
	0.0%	*25.0%*	*75.0%*	*100.0%*
Wales	0	0	3	3
	0.0%	*0.0%*	*100.0%*	*100.0%*
Overall	**7**	**1**	**99**	**107***
	6.4%	*0.9%*	*90.8%*	*98.2%*

*4 units did not provide data

Table 61: Availability of paediatricians with Level 3 safeguarding competencies by unit size

	09:00 to 17:00	09:00 to 21:00	24 hours a day, 7 days a week	Total
Very small	0	0	6	6
	0.0%	*0.0%*	*100.0%*	*100.0%*
Small	1	0	23	24
	4.3%	*0.0%*	*95.8%*	*100.0%*
Medium	5	1	48	54
	10.4%	*2.1%*	*88.9%*	*100.0%*
Large	1	0	21	22
	4.8%	*0.0%*	*95.5%*	*100.0%*
Size not available	0	0	1	1
	0.0%	*0.0%*	*100.0%*	*100.0%*
Overall	**7**	**1**	**99**	**107***
	7.1%	*1.0%*	*100.0%*	*100.0%*

*4 units did not provide data

Table 62: Availability for advice and assessment by country

	Advice and assessment	Advice only	Total
England	99	1	100
	99.0%	*1.0%*	*100.0%*
Northern Ireland	2	0	2
	100.0%	*0.0%*	*100.0%*
Scotland	4	0	4
	100.0%	*0.0%*	*100.0%*
Wales	3	0	3
	100%	*0%*	*100%*
Overall	**108**	**1**	**109***
	99.1%	*0.9%*	*100.0%*

*2 units did not provide data

Table 63: Availability for advice and assessment by unit size

	Advice and assessment	Advice only	Total
Very small	6	0	6
	100.0%	0.0%	100.0%
Small	25	0	25
	100.0%	0.0%	100.0%
Medium	54	1	55
	98.2%	1.8%	100.0%
Large	22	0	22
	100.0%	0.0%	100.0%
Size not available	1	0	1
	100.0%	0.0%	100.0%
Total	**108**	**1**	**109***
	99.1%	*0.9%*	*100.0%*

*2 units did not provide data

Table 64: Availability to non-health agencies by country

	Yes	No	Total
England	94	4	98
	95.9%	*4.1%*	*100.0%*
Northern Ireland	2	0	2
	100.0%	*0.0%*	*100.0%*
Scotland	4	0	4
	100.0%	*0.0%*	*100.0%*
Wales	3	0	3
	100.0%	*0.0%*	*100.0%*
Overall	**103**	**4**	**107***
	96.3%	*3.7%*	*100.0%*

*4 units did not provide data

Table 65: Availability to non-health agencies by unit size

	Yes	No	Total
Very small	6	0	6
	100.0%	*0.0%*	*100.0%*
Small	22	2	24
	91.7%	*8.3%*	*100.0%*
Medium	54	0	54
	100.0%	*0.0%*	*100.0%*
Large	20	2	22
	90.9%	*9.1%*	*100.0%*
Size not available	1	0	1
	100.0%	*0.0%*	*100.0%*
Overall	**103**	**4**	**107***
	96.3%	*3.7%*	*100.0%*

*4 units did not provide data

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