WM QRS West Midlands Quality Review Service

NHS

Care of Critically Ill & Critically Injured Children in the West Midlands

Worcestershire Acute Hospitals NHS Trust

Visit Date: 21st & 22nd May 2014 Report Date: August 2014

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INTRODUCTION

This report presents the findings of the review of the Care of Critically Ill and Critically Injured Children which took place on 21st and 22nd May 2014. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of Critically Ill and Critically Injured Children in the West Midlands, Version 4, March 2013

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services at Worcestershire Acute Hospitals NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Worcestershire Acute Hospitals NHS Trust
- NHS South Worcestershire Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group
- NHS Redditch and Bromsgrove Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Worcestershire Acute Hospitals NHS Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

CARE OF CRITICALLY ILL & CRITICALLY INJURED CHILDREN

ACUTE TRUST-WIDE

General Comments and Achievements

The care of children and young people was given a high priority at Worcestershire Acute Hospitals NHS Trust. Children were clearly made welcome on all three hospital sites. The Trust Board and senior managers were interested in the care of children and a Non-Executive Director was actively taking the role of 'children's champion' across the Trust. Paediatric services were also clearly supportive of other services across the Trust.

Good Practice

1 Arrangements for feedback from children, young people and families were well-developed and action taken as a result of feedback was clear. In the Emergency Departments all children and families were given a feedback leaflet after triage which they were asked to complete at the end of their care. An 'acorn and oak tree' board in the departments gave feedback on action taken. In the Emergency Department at Worcestershire Royal Hospital there were feedback boards, a weekly email and a 'topic of the week'. In paediatric services, children and families had the opportunity for electronic as well as paper feedback. Posters showed the actions taken as a result of feedback. For example, more fruit had been provided as a result of feedback. All documentation was particularly welcoming of suggestions for improving services. The information available showed that parent feedback had covered safety issues, for example, water collecting in a tube, as well as patient experience. At Kidderminster Treatment Centre feedback forms were handed out in the discharge lounge and two videos had been produced as a result of feedback to which all children and families were directed. Play specialists in all services were particularly involved in making sure feedback was obtained and action taken as a result. It was clear throughout the visit that feedback from children, young people and families was valued.

2 The Early Warning Protocol chart was clear and linked well with other protocols. In particular, the chart in use for young people aged 13 years and over linked with the adult tool as well as with the paediatric early warning system.

3 At Worcestershire Royal Hospital multi-disciplinary scenario training took place involving Emergency Department, paediatric and anaesthetic staff. The location for the training varied so that scenarios were practiced in the environment where staff usually worked.

4 The Trust Bereavement Policy was particularly clear, including about the needs of different faiths, and covered the death of children.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Anaesthetic cover at Alexandra Hospital**

The on-site middle grade anaesthetist at the Alexandra Hospital could, on occasions, be a CT3 or ST3 doctor who would not be expected to have competences in intubation of children. (The first on call anaesthetist would be either a CT1 or CT2.) The on call consultant would come in from home if additional help was required but there could be a delay of up to 30 minutes before the consultant arrived.

2 **Access to training records**

Medical staff training records for completion of resuscitation training were not easily available, especially for courses completed outside the Trust. As a result it was often difficult for clinical managers to know whether staff had completed appropriate training. This was sometimes recorded in their personal records but departmental or service reports summarising the information were not easily available. The lead

paediatric anaesthetist was unable to confirm which anaesthetists had completed child safeguarding training. In relation to child safeguarding training some staff who met the visiting team were unclear about the level of training they were expected to complete and whether they had had training to this level. In general, completion of training and staff confidence and awareness of training completed was better at Worcestershire Royal Hospital than at the Alexandra Hospital.

3 **Guidelines and Protocols**

Across the Trust a range of guidelines and protocols were in use. Some of these were localised showing how national guidance would be implemented locally whereas in other situations NICE or *Partners in Paediatrics* guidelines were accessed without localisation. This varied across the Trust, for example, in the Emergency Department at Worcestershire Royal Hospital localised guidelines were available but not in the Alexandra Hospital Emergency Department. Different staff also appeared to access different guidelines.

Further Consideration

1 Reviewers suggested that the Trust transfer protocol and the Paediatric Monitoring and Observation Guideline would benefit from review. Reviewers found these guidelines confusing and, at first glance inconsistent. Simplification of both policies with clearer labelling and flow charts may be helpful.

2 Multi-disciplinary resuscitation scenario training involving Emergency Department, paediatric and anaesthetic staff was no longer in place at the Alexandra Hospital. This was well-organised at Worcestershire Royal Hospital and reviewers suggested that re-introducing this at the Alexandra Hospital would be helpful, especially because of the relatively small number of children requiring resuscitation.

3 Adult and paediatric resuscitation trolleys were not differentiated visually. It may be helpful to consider introducing visual differentiation so that there is no opportunity for confusion. Also, resuscitation trolleys were not sealed or 'tagged'. Introduction of sealed trolleys in some areas may reduce the amount of staff time spent on checking trolleys and ensure that equipment and drugs are not removed after the trolley has been checked.

4 The arrangements for paediatric medical input to the development of guidelines and policies may benefit from review. Some appeared to have been developed by nurses without medical input. Some policies, for example, the transfer policy, had anaesthetic authors but not consultant paediatricians and some guidelines which concerned very important patient safety mechanisms, such as the Paediatric Monitoring and Observation guidelines did not have any paediatric consultant medical staff on the author list. Paediatric medical staff were involved in reviewing guidelines but the extent of input to the 'reviewing' process or responsibility for considering paediatric medical aspects were not clear.

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EMERGENCY DEPARTMENTS

General Comments and Achievements

The environment in both Emergency Departments was well-organised and staff were clearly committed to providing care for children. Emergency Department attendances for children and young people under the age of 16 years at the Alexandra Hospital were around 10,000 and 11,000 at Worcester Royal Hospital. Children attending the Emergency Department at the Alexandra Hospital had a nurse allocated to them so children and families were very clear who they should talk to if they had any queries. At Worcestershire Royal Hospital there were close links with paediatric services and paediatric staff would come and help in the Emergency Department at particularly busy times.

There was excellent commitment shown from adult trained nursing staff towards the care of children. Several staff who spoke to the reviewers took considerable pride in the training they had received and the guidance available from their paediatric colleagues.

Good Practice

1 The Emergency Department at Worcestershire Royal Hospital had very good pharmacy support. The on-site pharmacist was able to provide immediate advice on drug dosages and potential interactions. They were also able to take on the role of contacting other health professionals involved in the care of the patient to find out further details on their medication if required.

Immediate Risks: No immediate risks were identified.

Concerns

1 **See 'Concerns' in the Trust-wide section of this report.**

2 **Medical Staff Resuscitation Training – Alexandra Hospital**

At the Alexandra Hospital, evidence that junior medical staff in the Emergency Department had appropriate resuscitation training was not available. All consultants were appropriately trained.

3 **Care of Children with Trauma**

The Trust did not provide care for children with major trauma. It was, however, possible for children with trauma to arrive at either Emergency Department. Reviewers were concerned because:

a. At weekends one consultant covered both Emergency Departments and so could not guarantee to be available within 30 minutes in the event of a child with trauma arriving at the department.

b. Trauma guidelines did not meet all aspects of the Quality Standards, in particular, they were not clear about responsibilities of nursing staff or about handover.

c. Nursing staff had had limited training in care of children with trauma.

4 **Children's Trained Nurses**

Only 0.6 w.t.e children's trained nurses were available at the Alexandra Hospital and 2.4 w.t.e. at Worcestershire Royal Hospital. Neither department was therefore able to meet the expected Standards of one children's trained nurse in the department at all times. Recruitment had been tried but without success. Rotation between paediatric wards and Emergency Departments had been in place previously but was no longer operational.

5 **Checking of Resuscitation Trolleys**

New arrangements for checking resuscitation trolleys at Worcestershire Royal Hospital were introduced during the course of the review visit. Previous arrangements had relied on children's trained nurses who were not available daily. Worcestershire Acute Hospital NHS Trust committed to checking implementation of the new arrangements to ensure robust implementation.

Further Consideration

1 Neither department had a contingency plan or escalation policy showing how staffing levels would respond to fluctuations in the number and dependency of patients although, in practice, paediatric staff would provide support to the Emergency Department at Worcestershire Royal Hospital. Similar capacity was not available at the Alexandra Hospital.

2 The environment at the Alexandra Hospital Emergency Department was not particularly child-friendly. Some posters were displayed but there was limited patient information was available for children and young people. Redecoration was, however, taking place.

3 An 'initial assessment' flow diagram was available but this did not show the criteria for triage of children to different 'streams'. Decisions on 'streaming' were therefore dependent on the competence and confidence of the triage nurse. Reviewers were told of a variable level of diversion to GP out-of-hours services with higher diversion reported at the Alexandra Hospital.

IN-PATIENT SERVICES

General Comments and Achievements

In-patient services were provided on Ward 1 at the Alexandra Hospital (19 beds) and Riverbank Ward at Worcestershire Royal Hospital (35 beds).

All consultant paediatricians had given a clear commitment in the form of a 'pledge' that empowered nursing staff to call them if they were not happy with the condition of a child. The level of commitment and support for all staff was apparent throughout the visit.

The environment on the ward at Worcestershire Royal Hospital was especially bright and child-friendly.

Good Practice

1 The adolescent room at Worcestershire Royal Hospital and Ward 1 Young Person's Room at the Alexandra Hospital had particularly good, clear information for young people which was easily available.

2 Feedback from parents was valued and utilised to improve safety. For example, a suggestion from a parent led to a decision to switch to a different and more suitable product for delivery of oxygen to a particular group of children.

Immediate Risks: No immediate risks were identified.

Concerns

1 **See 'Concerns' in the Trust-wide section of this report.**

2 **Riverbank Ward – Resuscitation Trolley**

The resuscitation trolley on Riverbank Ward was not sealed and was kept in an easily accessible location. Reviewers were concerned that equipment could be taken from the trolley after it had been checked and not replaced.

Further Consideration

1 High dependency care was not formally commissioned from the Trust but both in-patient units provided a level of high dependency care. In particular, the wards cared for patients needing CPAP/HiFlo, patients in Diabetic Ketoacidosis (DKA), severe asthma and sepsis. Audits of the high dependency care provided by the Trust showed that appropriate nurse staffing levels were usually achieved although on occasions these would not have been adequate if a child's condition had deteriorated. Documentation of the operational policy for high dependency care was not clear and some relevant guidelines were not yet in place, for example, a localised guideline on the management of septic shock.

2 Arrangements for multi-disciplinary learning from incidents, complaints and positive feedback were not clear. A range of mechanisms were in place but it was not clear that the multi-disciplinary team providing children's services met together for this and ensured feedback to other staff about decisions reached. These arrangements may benefit from further consideration.

3 Details of an audit programme from April 2013 were available but the arrangements for ensuring audits were completed and learning implemented did not appear to be robust and may benefit from review. There was also a very basic audit (consisting of bar charts only) of how many high dependency patients had been cared for in 2012 and 2013 and there was no commentary or explanation to accompany the audit.

DAY SURGERY

KIDDERMINSTER TREATMENT CENTRE

General Comments and Achievements

Arrangements for providing day surgery at Kidderminster Treatment Centre were well-organised with highly committed staff and excellent segregation from adult patients. All members of the team worked well together to provide the service, including the consultant paediatrician remaining on site until all children had gone home. Staff tried to make the area more child-friendly by putting up posters on the day of surgery. Audits of patient experience had been used to improve the service offered, including the production of two videos for children and families which had been made available on 'YouTube'.

Concerns

1 **Resuscitation Trolley**

The lack of differentiation between paediatric and adults trolleys had the potential to cause confusion in an emergency. This was being addressed by using different covers for the paediatric trolleys but new arrangements should be checked to ensure full implementation has been achieved.

Further Consideration

1 It was unclear whether the paediatric day surgery group was still meeting. If not, other arrangements for ensuring ongoing liaison between anaesthetic, paediatric and surgical staff will need to be put in place.

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PAEDIATRIC ANAESTHESIA

General Comments and Achievements

Anaesthetic leads throughout the Trust were highly committed to providing good quality care for children, with a strong emphasis on the importance of safety, training, keeping up to date, and availability and checking of equipment. A strong culture of support and advice, especially for those with less experience in the care of children, was evident. Non-anaesthetic staff throughout the Trust gave good, positive feedback on the willingness of anaesthetic staff to attend and provide support for the care of children. All surgical patients were admitted under the care of a consultant paediatrician which helped coordination of care.

Good Practice

1 Videos for children and young people preparing for surgery were easily available and used throughout the Trust.

2 Pre-assessment clinics were in general, well-organised at the Kidderminster Treatment Centre and Worcester Royal Hospital. General surgery pre-assessment was linked with out-patient clinics and this saved a second visit to hospital as surgical, anaesthetic and nursing preparation were undertaken on the same visit.

3 A monthly Magnetic Resonance Image (MRI) under general anaesthetic list was run at Worcestershire Royal Hospital.

4 At the Alexandra Hospital children went straight to theatre with a parent and a nurse without having to wait in a holding bay.

Immediate Risks: No immediate risks were identified.

Concerns

1 See Trust-wide concern in relation to anaesthetic cover at the Alexandra Hospital.

2 **Anaesthetist – Ongoing Competence in Care of Children**

Some anaesthetists were anaesthetising very small numbers of children, especially at the Alexandra Hospital. A high proportion of anaesthetists had undertaken Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training (15/17 at the Alexandra Hospital and 18/26 at Worcestershire Royal Hospital) but for other anaesthetists there was not evidence of relevant Continuing Professional Development and ongoing confidence in intubation of children may not be being maintained. Arrangements for ensuring ongoing competence and confidence should be considered, for example, by attending sessions at Kidderminster Treatment Centre.

Further Consideration

1 At the Alexandra Hospital approximately four urology patients per month did not receive nursing pre-operative assessment. A protocol had been introduced for ophthalmology patients to ensure all necessary assessments were completed pre-operatively and it may be helpful to consider a similar arrangement for urology patients.

2 At the Alexandra Hospital paediatric anaesthesia audits had not been undertaken since September 2012 due to staff sickness and maternity leave. Arrangements for ensuring ongoing leadership of paediatric anaesthesia during absences of the paediatric lead may benefit from review**.**

3 Theatre recovery at Worcestershire Royal Hospital did not have a separate resuscitation trolley and reviewers suggested that this would be helpful.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Philip Wilson	KIDS Lead Nurse	Birmingham Children's Hospital NHS Foundation Trust

Visiting Team

Dr Abigail Akita	Consultant Anaesthetist	The Royal Wolverhampton NHS Trust
Kate Davis	Patient Representative	
Elaine Day	Patient Representative	
Sue Ellis	Lead Nurse Paediatrics & Neonatology	University Hospitals Coventry & Warwickshire NHS Trust
Dr Drusilla Ferdinand	Consultant Paediatrician	Walsall Healthcare NHS Trust
Dr Afeda Mohamed Ali	PICU Consultant	Birmingham Children's Hospital NHS Foundation Trust
Brenda Taylor	A&E Sister	Heart of England NHS Foundation Trust
Helen Whitehouse	Paediatric Sister	Heart of England NHS Foundation Trust
Dr Bridget Wilson	Consultant in Paediatric Emergency Medicine	Birmingham Children's Hospital NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Care of Critically Ill & Critically Injured Children			
Acute Trust-wide	9	8	89
Emergency Department: Alexander Hospital, Redditch	44	33	75
Emergency Department: Worcestershire Royal Hospital	44	35	80
In-patient Service: Alexander Hospital, Redditch	51	42	82
In-patient Service: Worcestershire Royal Hospital	51	44	86
Day Surgery: Kidderminster Treatment Centre	33	29	88
Paediatric Anaesthesia	16	13	81
Total	**248**	**204**	**82**

Pathway and Service Letters: The Standards are in the following sections:

PC-	Care of Critically Ill Children Pathway	Acute Trust-wide
PM-	Care of Critically Ill Children Pathway	Core Standards for Each Area: Emergency Departments, Children's Assessment Services, In-patient and High Dependency Care Services for Children
PE-	Care of Critically Ill Children Pathway	Emergency Departments Caring for Children
PQ-	Care of Critically Ill Children Pathway	In-patient and High Dependency Care Services for Children
PG-	Care of Critically Ill Children Pathway	Anaesthesia and General Intensive Care for Children

Topic Sections: Each section covers the following topics:

-100	Information and Support for Children and Their Families
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

ACUTE TRUST-WIDE

Ref	Quality Standards	Met?	Comments
PC-201	**Board-level lead for children** A Board-level lead for children's services should be identified.	Y	
PC-202	**Lead consultants and lead nurses** The Board level lead for children's services should ensure that the following leads for the care of children have been identified: a. Nominated lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Nominated lead consultant for emergency and elective surgery in children c. Nominated lead consultant for trauma in children d. Nominated lead anaesthetist (QS PG-201) and lead ICU consultant (QS PG-202) for children	Y	The lead nurse in Emergency Department at Worcestershire Royal Hospital was on maternity leave and was being covered by a nurse who was not children's trained.
PC-501	**Minor injuries units** If the Trust's services (QS PC-601) include a Minor Injuries Unit, Walk-in Centre or Urgent Care Centre, this Unit should have a protocol in use in the event of a critically ill child, or potentially critically ill child, presenting. This protocol should include transfer to an appropriate paediatric unit.	Y	
PC-502	**Hospitals with emergency services for adults only – avoiding child attendances** Hospitals without on-site assessment or in-patient services for children should: a. Indicate clearly to the public the nature of the service provided for children b. Have agreed a protocol with the local ambulance service that children are not brought to the service by ambulance	N/A	
PC-503	**Hospitals with emergency services for adults only – paediatric advice** Hospitals without on-site assessment or in-patient services for children should have guidelines for accessing paediatric medical advice agreed with a local paediatric medical unit and regularly reviewed.	N/A	
PC-504	**Surgery on children** The Trust should have agreed the exclusion criteria for elective and emergency surgery on children (QS PG-503).	Y	

Ref	Quality Standards	Met?	Comments
PC-601	**Services provided** The Trust should be clear whether it provides the following services and the hospital site or sites on which each service is available: a. Minor Injury Unit, Walk-in Centre or Urgent Care Centre b. Emergency Department for: • Adults • Children c. Trauma service for children and, if so, its designation d. Children's assessment service e. In-patient children's service f. High Dependency Care service for children g. Elective in-patient surgery for children h. Day case surgery for children I. Emergency surgery for children j. Acute pain service for children k. Paediatric Intensive Care retrieval and transfer service l. Paediatric Intensive Care service	Y	See main report in relation to high dependency care.
PC-602	**Children's assessment service location** If the Trust provides a children's assessment service, this should be sited alongside either an Emergency Department or an in-patient children's service.	N/A	
PC-603	**Hospitals accepting children with trauma** Hospitals accepting children with trauma should also provide, on the same hospital site: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: • A short period of post-anaesthetic care • Maintenance prior to transfer to PICU (QS PM-506)	N	Children were not admitted to the general intensive care unit at Worcestershire Royal Hospital.
PC-604	**Trust-wide group** Trusts providing hospital services for children should have a single group responsible for the coordination and development of care of critically ill and critically injured children. The membership of this group should include all nominated leads (QS PC-202) and the Resuscitation Officer with lead responsibility for children. The accountability of the group should include the Trust Director with responsibility for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children (QS PM-297) and clinical governance issues relating to children should be clear.	Y	The configuration of groups had changed in April 2014. The previous 'paediatric surgery and care of critically ill children' group had been replaced by a 'Children's Standards Committee' which linked with the Trust 'Children's Board'.

Ref	Quality Standards	Met?	Comments
PC-703	**Approving guidelines and policies** The mechanism for approval of policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should have been agreed by the Trust-wide group (QS PC-604) or a sub-group thereof.	Y	As QS PC-703. It may be helpful to review the arrangements for ensuring medical input to the development of guidelines. Several had nurse-only authors. Although these had been reviewed by a range of medical staff it was not clear that any consultant was taking responsibility for considering the medical aspects of these guidelines.
PC-704	**Child death** The death of a child while in hospital should undergo formal review. This review should be multi-professional and all reasonable steps should be taken to involve specialties who contributed to the child's care. Primary and community services should be involved where appropriate. All deaths of children in hospital should be reported to the local Child Death Overview Panel.	Y	

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Emergency Departments: Alexandra Hospital, Redditch (AH) and Worcestershire Royal Hospital (WRH)

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	Y	
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	N	Y	At the Alexandra Hospital there were separate cubicles and a waiting area for children but the environment was not child-friendly although it was being re-decorated. At Worcestershire Royal Hospital the children's Emergency Department was completely separate from adult patients although, in practice, the children's waiting area was used only by children aged 12 and under.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	N	N	At Alexandra Hospital an asthma leaflet was available but not other information for children and young people. At Worcestershire Royal Hospital information for children and young people was not easily available. It would be printed out for individual children although it was not clear that this always took place.
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	Y	
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	Y	Children who attended the Emergency Department had a nurse allocated to them during their stay.
PM-107	**Information for parents of children needing transfer** Parents of children needing emergency transfer should be given all possible help regarding transport, hospital location, car parking and location of the unit to which their child is being transferred.	Y	Y	A KIDS (Kids Intensive Care and Decision Support) poster was displayed and staff would print the information from the KIDS website when required.
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	Y	A Trust-wide policy was in place although some staff were not aware of the policy.
PM-199	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	Y	Y	See main report.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	N	At Worcestershire Royal Hospital there was a nominated consultant and senior nurse who was not, however, children's trained. A link with a more junior children's trained nurse had been put in place but this nurse was on long-term leave.
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	Y	At weekends the Emergency Department consultant covered both the Redditch and Worcester sites.
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	Y	
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	N	Y	See main report (Trust-wide section) in relation to the level of competences of on-site anaesthetic staff at the Alexandra Hospital.
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	Y	Y	Locum staff were sometimes used on the middle grade rota. The Trust policy was to ensure that all locum staff had APLS. It was not clear that this was always achieved at the Alexandra Hospital.
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	N	N	At Worcestershire Royal Hospital nursing staff had undertaken adult-based trauma training but not training on caring for children with trauma. Neither department had an escalation policy although, in practice, at Worcestershire Royal Hospital paediatric staff would provide support to the Emergence Department.
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	N	N	The Alexandra Hospital Emergency Department had only 0.6 w.t.e and at Worcestershire Royal Hospital only four children's trained nurses were available. It was therefore not possible for one children's trained nurse to be on duty at all times. Rotation with paediatric wards had been tried previously but had ceased. Re-introducing the rotation was being considered.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	Y	Y	
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N/A	N/A	Both Emergency Departments saw less than 16,000 children per year.
PE-212	**Trauma team** Emergency Departments receiving children with trauma should have a Trauma Team immediately available at all times, including: a. Team Leader (see note 2) b. Emergency Department doctor (senior decision maker) c. Clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above (QS PQ-217) d. Clinician with competences in resuscitation, stabilisation and intubation of children (QS PM-203) e. General Surgeon f. Orthopaedic Surgeon	N	N	The Emergency Department consultant covered both sites at weekends. Documented procedures did not cover what staff should do if the Emergency Department consultant could not attend. In practice, the on-call intensivist would be called.
PE-213	**ED liaison paediatrician** There should be a nominated paediatric consultant responsible for liaison with the nominated Emergency Department consultant (QS PM-201).	Y	Y	
PE-214	**ED sub-speciality trained consultant** Emergency departments seeing 16,000 or more child attendances per year should have an emergency department consultant with sub-specialty training in paediatric emergency medicine and a consultant paediatrician with sub-specialty training in paediatric emergency medicine.	N/A	N/A	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PE-215	**Small emergency departments** Emergency departments seeing less than 16,000 child attendances per year should have arrangements in place to ensure the ongoing competence of clinical staff in the care of critically ill children.	N	Y	Arrangements for ensuring ongoing competence in the care of critically ill children were not clear at Alexandra Hospital. Joint scenario training with paediatric staff had taken place in the past but was no longer happening. At Worcestershire Royal Hospital a paediatric training day was run by Advanced Nurse Practitioners (although these staff were not children's trained nurses). Simulation training also took place with paediatric and anaesthetic staff. The location for this training varied so that scenarios were practiced in the environment where staff usually worked.
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	N	A policy on staff acting outside their area of competence was not yet in place.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	Y	Y	See main report (Trust-wide section).
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PE-302	**Critical care support** Emergency Departments accepting children with trauma should have access, on the same hospital site, to: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: • A short period of post-anaesthetic care • Maintenance prior to transfer to PICU (QS PM-506)	Y	N	At Worcestershire Royal Hospital children were not admitted to the general intensive care unit.
PM-401	**Resuscitation equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	N	At Worcestershire Royal Hospital a resuscitation trolley with appropriate drugs and equipment was available but this was not checked regularly. Sometimes there were gaps of several days in checking the trolley. This had been noted the previous month but had not been addressed. See main report.
PM-501	**Initial Assessment** A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times exceed 30 minutes.	Y	Y	See main report (further consideration section).
PM-502	**Paediatric advice** Protocols for accessing advice from the local paediatric service and local paediatric intensive care service should be in use in units where children are not under the care of a paediatrician.	Y	Y	
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	N	Y	At Alexandra Hospital staff had varying views about the guidelines they would use. A guidelines folder was mentioned but was not available in the Emergency Department on the day of the visit. Partners in Paediatrics guidelines were available but did not cover 'c'. At Worcestershire Royal Hospital a protocol booklet with additional information about local implementation of guidelines was available.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	Y	A good observation chart linked PEWS (Paediatric Early Warning System) with PARS (Patient at Risk Score, an adult tool) and was used from 13 years onwards. A high dependency observation chart was also used. Medical input to the development of the policy was not clear and the policy was inconsistent with the transfer policy.
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	Y	Y	
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO	Y	Y	
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	Y	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	N/A	The Trust may wish to consider development of this protocol if service re-configuration changes are made.
PM-509	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer	Y	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	Y	
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	Y	
PE-511	**Trauma protocol** A protocol on care of children with trauma should be in use covering: a. Dedicated phone in the Emergency Department b. Alerting and activating the Trauma Team (QS PE-212) c. Handover from the pre-hospital team to the Trauma Team lead using ATMIST d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants e. Involvement of neurosurgeons in all decisions to operate on children with traumatic brain injury f. Indications and arrangements for referral to the Major Trauma Centre for children, including referral of children needing assessment for: i. Neurosurgery ii. Vascular surgery iii. Cardiothoracic surgery iv. Spinal cord service v. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Responsibilities for recording receipt of imaging reports j. Major incidents	N	N	Points ‘a', 'b', 'c', 'e' and 'f' were met. Available protocols did not cover the role of nursing staff in the care of patients with trauma. Points 'g' and 'h' were not covered clearly in the available protocols. Reviewers noted that at Worcestershire Royal Hospital paediatric staff appeared to be more involved than at Alexandra Hospital.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PE-512	**Trauma guidelines** Guidelines should be in use covering care of children with trauma, including: a. Immediate airway management b. Haemorrhage control and massive transfusion c. Chest drain insertion	N	Y	At Alexandra Hospital guidelines on haemorrhage control and massive transfusion related to adults only. At Worcestershire Royal Hospital a link to a paediatric policy was in place.
PE-513	**Trauma imaging** A protocol on imaging of children with trauma should be in use which ensures: a. Where indicated, CT is the primary imaging modality b. CT scanning is undertaken within 30 minutes of arrival c. Electronic transmission of images for immediate reporting d. A provisional report is issued within one hour and communicated by telephone and electronically e. Indications and arrangements for review of imaging by a neuro-radiologist f. Full report is issued electronically within 12 hours g. Any significant variations between the provisional and final report are communicated to the senior clinician responsible for the care of the child h. Responsibilities of other services for recording receipt of imaging reports	Y	Y	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	Y	Y	
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	Y	
PM-798	**Review and learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	Y	Y	Arrangements for review and learning at Worcestershire Royal Hospital were particularly good with weekly emails and monthly feedback meetings.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	Y	

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IN-PATIENT SERVICES: ALEXANDRA HOSPITAL, REDDITCH (AH) AND WORCESTERSHIRE ROYAL HOSPITAL (WRH)

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	Y	
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	Y	Y	At Worcestershire Royal Hospital the environment was excellent and particular care had been taken with meeting the needs of young people. A very good room for young people was available and stocked with excellent information. The outside play area was also good.
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	Y	Information was available, especially for young people. Information for younger children could be requested but was less obviously available.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	Y	
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	Y	
PM-107	**Information for parents of children needing transfer** Parents of children needing emergency transfer should be given all possible help regarding transport, hospital location, car parking and location of the unit to which their child is being transferred.	Y	Y	A KIDS poster was displayed and staff would print the information from the KIDS website when required.
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	Y	A Trust-wide policy was in place although some staff were not aware of the policy.
PQ-108	**Parent information for in-patients** Parents should be given written information about the unit, including visiting arrangements, ward routine and location of facilities within the hospital that the parents may want to use.	Y	Y	Leaflets were displayed outside the parent's room at Alexandra Hospital. There was also a 'parents board' in the main ward area. Information was also accessible via the website. Information in different languages could be requested although the information about this could be more clearly displayed.
PQ-109	**Parent facilities for in-patients** Facilities should be available for the parent of each child, including: a. Somewhere to sit away from the ward b. A quiet room for relatives c. A kitchen, toilet and washing area d. A changing area for other young children	Y	N	At Alexandra Hospital work was underway to address concerns raised by parents about the bathroom and adjoining sluice room. At Worcestershire Royal Hospital there was only one parents' toilet which was off the bedroom for parents. If the bedroom was in use, other parents had to use the staff toilet.
PQ-110	**Overnight facilities** Overnight facilities should be available for the parent or carer of each child, including a foldaway bed or pull-out chair-bed next to the child.	Y	Y	At Alexandra Hospital six ' Z' beds were available and a reclining chair in the High Dependency Unit cubicle. A parent's room was available at Worcestershire Royal Hospital in addition to 'Z' beds.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PQ-111	**Overnight facilities – high dependency care services** Units which provide high dependency care should have appropriate facilities for parents and carers to stay overnight, including accommodation on site but away from the ward.	Y	Y	
PM-199	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	Y	Y	See main report.
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	Y	
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	Y	Consultant paediatricians had signed a 'pledge' formalising the process whereby staff could contact a consultant if they had concerns about any child. Staff who met the visiting team felt supported and commented that consultants would attend the ward on these occasions.
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	Y	
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	N	Y	See main report (Trust-wide section) in relation to the level of competences of on-site anaesthetic staff at the Alexandra Hospital.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	N	Y	APLS training for one consultant at Alexandra Hospital was out of date. Locum staff were sometimes used on the middle grade rota. The Trust policy was to ensure that all locum staff had APLS. It was not clear that this was always achieved at the Alexandra Hospital.
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	Y	Y	
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	Y	Y	
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	Y	Y	Compliance for Alexandra Hospital is based on the reported achievement of resuscitation training. Documentation was not clear.
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N	Y	At Alexandra Hospital support for play was available from Monday to Friday only. The Quality Standard was met at Worcestershire Royal Hospital at the time of the review but may not be met in future due to staffing changes.
PQ-216	**High dependency care: lead consultant and lead nurse** A nominated paediatric consultant and lead nurse should have responsibility for guidelines, policies and procedures (QS PQ-601) and staff competences relating to high dependency care. The consultant should undertake Continuing Professional Development of relevance to high dependency care. The lead nurse should be a senior children's trained nurse with competences and experience in providing high dependency care.	Y	Y	
PQ-217	**Clinician with level 2 competences on duty** A clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above should be available on site at all times.	Y	Y	
PQ-218	**High dependency care: nursing competences** Children needing high dependency care should be cared for by a trained children's nurse with paediatric resuscitation training and competences in providing high dependency care.	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PQ-219	**High dependency care: nurse staffing** Nurse staffing for children needing high dependency care should be 0.5:1 or 1:1 if nursed in a cubicle. If this is achieved through flexible use of staff (rather than rostering) then achievement of expected staffing levels should have been audited.	Y	Y	Audits relating to both sites showed that 1:1 nursing for children needing high dependency care was occasionally not met but there was a recorded explanation for each giving the reasons why this was not required clinically.
PQ-220	**Tracheostomy care** If children with tracheostomies are cared for on the ward, a healthcare professional with skills in tracheostomy care should be rostered on each shift.	N/A	N/A	Children with tracheostomies were not admitted to the ward.
PQ-221	**High dependency care: pharmacy and physiotherapy** Wards providing high dependency care should have pharmacy and physiotherapy staff with appropriate competences and job plan time allocated for their work with children needing high dependency care.	N	N	Pharmacy and physiotherapy staff were available but did not have time allocated for work with children needing high dependency care.
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	N	A policy on staff acting outside their area of competence was not yet in place.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	Y	Y	See main report (Trust-wide section).

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	Y	Y	
PQ-303	**Other specialties** Access to other appropriate specialties should be available, depending on the usual case mix of patients, for example, 24-hour ENT cover for tracheostomy care.	Y	Y	
PQ-304	**Intensive care support** 24-hour on-site access to a senior nurse with intensive care skills and training should be available.	Y	Y	
PM-401	**Resuscitation equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	Y	See main report in relation to access to the resuscitation trolleys especially at Worcestershire Royal Hospital.
PQ-402	**High dependency care: facilities and equipment** An appropriately designed and equipped area for providing high dependency care for children of all ages should be available. Equipment available should be appropriate for the high dependency care and interventions provided (QS PQ-601). Drugs and equipment should be checked in accordance with local policy.	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	N	N	Some guidelines were not localised, e.g. meningococcal sepsis and there were not guidelines for point 'c'. At Alexandra Hospital ward staff said that they would access NICE (National Institute for Health and Care Excellence) guidance in the first instance and then Partners in Paediatrics guidance. At Worcestershire Royal Hospital staff said they would access local guidelines to start with, then NICE guidance and finally Partners in Paediatrics guidance but consultants varied in their approach which could be confusing for junior staff.
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	Y	A good observation chart linked PEWS with PARS (adult tool) and was used from 13 years onwards. A high dependency observation chart was also used. Medical input to the development of the policy was not clear and the policy was inconsistent with the transfer policy.
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO	Y	Y	
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	Y	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	N/A	The Trust may wish to consider development of this protocol if service re-configuration changes are made.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-509	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer	Y	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	Y	
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	Y	

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PQ-514	**High dependency care: clinical guidelines** Clinical guidelines should be in use covering the provision of high dependency care, including: a. Care of children with: i. Bronchiolitis ii. Status epilepticus iii. Diabetic ketoacidosis iv. Long-term ventilation b. High dependency interventions (QS PQ-601). c. Rehabilitation of children following trauma (if applicable)	Y	Y	Children on long-term ventilation were not admitted to the ward.
PQ-601	**High dependency care: operational policy** Wards providing high dependency care should have an operational policy covering: a. Type of children (age and diagnoses) for whom high dependency care will normally be provided b. Expected duration of high dependency care c. High dependency interventions provided, and duration of interventions, including whether the following are provided: i. Invasive monitoring ii. CPAP iii. Renal support d. Expected competences of healthcare staff providing high dependency interventions e. Arrangements for access to paediatric radiology advice f. Arrangements for liaison with lead PICU for advice and support	N	N	No operational policy was in place even though high dependency care was provided.
PQ-701	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS.	Y	Y	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	N	N	A list of audits was available but there was no evidence of monitoring completion of these audits or 'closing the loop'. Audit results were discussed at audit meetings but the mechanisms for sharing the learning with those staff not present at those meetings was not clear.

Ref	Quality Standards	Met? AH	Met? WRH	Comments
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	Y	
PM-798	**Review and learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	N	N	Multi-disciplinary arrangements for review and learning were not clear. Some communication happened during handovers. Nursing staff had monthly feedback from Trust-wide arrangements. Governance meetings took place with videoconferencing between sites although this was not mentioned by staff at Alexandra Hospital. A quarterly risk bulletin was in place. It was not clear, however, that the multi-disciplinary paediatric clinical team met together for review and learning.
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	Y	

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DAY SURGERY: KIDDERMINSTER TREATMENT CENTRE

Ref	Quality Standards	Met?	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	Y	Children only lists took place on a weekly basis. Some posters were put on the walls to make the area more child friendly during these sessions.

Ref	Quality Standards	Met?	Comments
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	N/A	See paediatric anaesthesia section of this report.
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	N/A	See paediatric anaesthesia section of this report.
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	
PM-107	**Information for parents of children needing transfer** Parents of children needing emergency transfer should be given all possible help regarding transport, hospital location, car parking and location of the unit to which their child is being transferred.	N/A	
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	A Trust-wide policy was in place although some staff were not aware of the policy.
PM-199	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	Y	See main report.
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	A consultant paediatrician was always in the outpatient clinic whilst the paediatric theatre lists were running including remaining on site until all children went home.

Ref	Quality Standards	Met?	Comments
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	Y	
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	Y	
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	Y	
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	This Quality Standard was met by consultant presence during the time children were on site.
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	Y	

Ref	Quality Standards	Met?	Comments
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	Y	
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	Y	
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	A policy on staff acting outside their area of competence was not yet in place.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	Y	See main report (Trust-wide section).
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	N	Laboratory services were not available on site. Blood samples and blood gasses were sent to Worcestershire Royal Hospital. A stock of pharmaceuticals was available on site but not a pharmacy service.
PM-401	**Resuscitation equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	Adult and paediatric trolleys were the same colour. Clear labelling or other way of distinguishing trolleys may be helpful so that there is no potential for confusion between the trolleys.

Ref	Quality Standards	Met?	Comments
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	Y	Applicable guidelines were available. Staff said they would access local guidelines to start with, then NICE guidance and finally Partners in Paediatrics guidance but consultants varied in their approach which could be confusing for junior staff.
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	Y	
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO	Y	
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.

Ref	Quality Standards	Met?	Comments
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	
PM-509	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer	Y	See main report (Trust-wide 'further consideration') in relation to revisions to this protocol.
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	

Ref	Quality Standards	Met?	Comments
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	N	As in-patient paediatrics.
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	
PM-798	**Review and learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	N	A paediatric surgery group had met in the past. It was not clear if this group was still meeting and staff in theatres commented that they did not always get feedback on the issues discussed.
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	

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PAEDIATRIC ANAESTHESIA

Ref	Quality Standards	Met?	Comments
[PC-601]	**Surgery and anaesthetic services** The Trust should be clear whether it provides the following services for children and the hospital site or sites on which each service is available: a. Elective in-patient surgery for children b. Day case surgery for children c. Emergency surgery for children d. Acute pain service for children	Y	
PG-102	**Information on anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	Y	Paper-based information was available and also good on-line videos.

Ref	Quality Standards	Met?	Comments
PG-199	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	Y	Feedback from children and families was clearly displayed and presented.
PG-201	**Lead anaesthetist** A nominated consultant anaesthetist should be responsible for policies and procedures relating to emergency and elective anaesthesia of children. This consultant should be involved in the delivery of anaesthetic services to children.	Y	Leads for all three sites were identified as well as an overall Trust lead.
PG-202	**GICU lead consultant** A nominated lead intensive care consultant should be responsible for Intensive Care Unit policies and procedures relating to children.	N/A	
PG-203	**Lead nurse** A nominated lead nurse should be responsible for ensuring policies, procedures and nurse training relating to children admitted to the general intensive care unit are in place.	N/A	
PG-204	**Medical staff caring for children** All anaesthetists or intensivists with emergency and / or elective paediatric responsibility should have up to date knowledge of advanced paediatric life support / resuscitation and stabilisation of critically ill children.	N	A high proportion of anaesthetists had completed APLS or EPLS training (15/17 at Alexandra Hospital and 18/26 at Worcestershire Royal Hospital). For other anaesthetists there was not evidence of up to date knowledge of paediatric life support, resuscitation and stabilisation.
PG-205	**Elective anaesthesia** All anaesthetists involved in the elective surgical management of children should be familiar with current practice and the techniques necessary to provide safe care for children, including acute pain management.	Y	
PG-206	**Operating department assistance** Operating department assistance from personnel trained and familiar with paediatric work should be available for all emergency and elective children's surgery. For hospitals accepting children with trauma, this includes competences in the care of children with trauma.	N	From the evidence seen by reviewers some staff had not completed safeguarding training.
PG-207	**Recovery staff** At least one member of the recovery room staff who has training and experience in paediatric practice should be available for all elective children's lists.	Y	

Ref	Quality Standards	Met?	Comments
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	N	The approach and atmosphere was child-friendly at all three sites. The physical environment had not yet been made child-friendly.
PG-402	**Day surgery** Children needing elective surgery should be admitted to a day surgery unit or a children's ward area specifically identified for children's day surgery.	Y	
PG-403	**Drugs and equipment** Appropriate drugs and equipment should be available in each area in which paediatric anaesthesia is delivered. Drugs and equipment should be checked in accordance with local policy.	Y	The recovery area at Worcestershire Royal Hospital did not have a separate paediatric resuscitation trolley and reviewers suggested that this would be helpful.
PG-404	**GICU paediatric area** The general intensive care unit should have an appropriately designed and equipped area for providing intensive care for children. Drugs and equipment appropriate to the age and condition of children who may be admitted (QS PM-506) should be available and checked in accordance with local policy.	N/A	
PG-501	**Role of anaesthetic service in care of critically ill children** Protocols for resuscitation, stabilisation, accessing advice, transfer and maintenance of critically ill children (QSs PM-503 to PM-509) and the provision of high dependency care (QS PQ-514 and PQ-601) should be clear about the role of the anaesthetic service and (general) intensive care in each stage of the child's care.	Y	
PG-502	**GICU Care of children** If the maintenance guidelines in QS PM-506 include the use of a general intensive care unit, they should specify: a. The circumstances under which a child will be admitted to and stay on the general intensive care unit b. A children's nurse is available to support the care of the child and should review the child at least every 12 hours c. There should be discussion with a PICU about the child's condition prior to admission and regularly during their stay on the general intensive care unit d. A local paediatrician should agree to the child being moved to the intensive care unit and should be available for advice e. A senior member of the paediatric team should review the child at least every 12 hours during their stay on the general intensive care unit	N/A	

Ref	Quality Standards	Met?	Comments
PG-503	**Surgery criteria** Protocols should be in use covering: a. Exclusion criteria for elective and emergency surgery on children b. Day case criteria c. Non-surgical procedures requiring anaesthesia	Y	
PG-504	**Clinical guidelines - anaesthesia** Clinical guidelines should be in use covering: a. Analgesia for children b. Pre-operative assessment c. Preparation of all children undergoing general anaesthesia	Y	
PG-601	**Liaison with theatre manager** There should be close liaison between the lead consultant/s for paediatric anaesthesia (QS PG-201) and the Theatre Manager with regard to the training and mentoring of support staff.	Y	
PG-602	**Children's lists** Wherever possible, elective surgery on children should be undertaken on dedicated operating lists for children. If dedicated lists are not feasible, children should be put at the start of lists with appropriately trained staff in the reception, anaesthetic room, theatre and recovery areas.	Y	
PG-701	**High dependency care: data collection (GICU)** The paediatric high dependency minimum data set should be collected and submitted to SUS.	N/A	

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