WM QRS West Midlands Quality Review Service

NHS

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

The Shrewsbury and Telford Hospital NHS Trust

Visit Date: 12th May 2015 Report Date: August 2015

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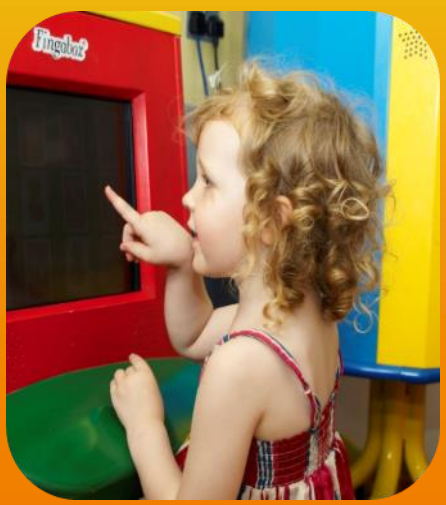

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INTRODUCTION

This report presents the findings of the review of the care of critically ill and critically injured children that took place on 12th May 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of Critically Ill and Critically Injured Children in the West Midlands, Version 4.2, December 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 The Shrewsbury & Telford Hospital 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:

- The Shrewsbury & Telford Hospital NHS Trust
- NHS Shropshire Clinical Commissioning Group
- NHS Telford and Wrekin 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. The lead commissioners in relation to this report are Shropshire and Telford & Wrekin Clinical Commissioning Groups.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is 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 The Shrewsbury & Telford Hospital 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.

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CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

TRUST-WIDE

Children's services had been re-configured in September 2014 leading to the creation of a Women and Children's Centre at Princess Royal Hospital (PRH). All children and young people needing hospital admission were admitted to this Centre. Some care of children still took place at Royal Shrewsbury Hospital (RSH). The services available on each site at the time of the review were as follows:

Princess Royal Hospital Telford (PRH)	**Royal Shrewsbury Hospital (RSH)**
36 bedded inpatient ward including 4 designated beds for children requiring higher level of observation, and 3 dedicated oncology beds	No in-patient service provided
8 bedded Children's Assessment Unit offering 7 day a week 24 hour access	6 bedded Children's Assessment Unit offering 7 days a week services Monday-Friday: 09.00-22.00 (last admission 20:00) Saturday and Sunday: 12.00-22.00 (last admission 20.00)
Paediatric outpatients	Paediatric outpatients
General Emergency Department (ED) with separate children's waiting area. "GP at the door service" that worked closely with ED. The service was located within the ED during weekdays and next door to the ED at weekends. This service operated from 10.00am-10.00pm 7 days a week.	General Emergency Department (designated Trauma Unit for children & adults) with separate children's waiting area. An Urgent Care Centre was located next door to the Emergency Department. The service operated from 08.00am-8.00pm 7 days a week and worked closely with the ED.
Day surgery unit. Dedicated days and areas for paediatric day surgery	No day surgery
Emergency Surgery	Time-critical (life/limb/eye-saving) emergency surgery only

General Comments and Achievements

Reviewers were impressed by the re-configuration which had been achieved and the clinical involvement in planning the new service. Staff who met reviewers were enthusiastic and open, with insight into the problems facing services and the changes which still needed to be made. Staff had taken the opportunity provided by the reconfiguration to review policies and procedures.

Good Practice

1 Good multi-disciplinary scenario training took place monthly on both sites. A range of clinical staff and resuscitation training staff were involved in these scenarios.

2 Shropshire Young Health Champions were actively involved in improving services for children and young people across the Trust.

3 Arrangements for GPs to have direct discussion with consultant paediatricians for advice and triage of referrals were in place, through the Clinical Coordination Centre. This service was highly appreciated by GPs.

4 Patient pathways were clearly defined and had been agreed with the ambulance service, including clear guidance on which patients should be taken directly to Princess Royal Hospital.

5 The 'Casualty Cards' used in both Emergency Departments were clear and comprehensive. Reviewers were particularly impressed that the important information, including about safeguarding, could be seen quickly and easily.

6 The 'Tops and Pants' method of capturing children's feedback about the service was innovative. Children completed a 'top' if they wished to comment on something positive or 'pants' if they thought something was bad or could be improved. Comments were then hung on a 'washing line'.

Immediate Risks

1 **Availability of oxygen and suction**[1]

Oxygen and suction equipment in the in-patient and children's assessment units was not set up ready for use. Oxygen tubing and masks were not linked to the oxygen flow metres or suction equipment to the vacuum jar in at least five occupied beds observed by reviewers. Reviewers were told that the relevant oxygen and suction equipment was stored in the bedside lockers (Princess Royal Hospital) or store room (Royal Shrewsbury Hospital). Reviewers checked two lockers (beside unoccupied beds) and neither contained oxygen tubing and mask or suction equipment. This was considered to be an immediate risk because of the potential delay introduced by setting up oxygen and suction, especially if the oxygen and suction equipment was not in the bedside locker and had to be sourced from elsewhere. It was also not clear how staff were checking (prior to use) that the equipment was working properly.

Concerns

1 **Children from Powys with safeguarding concerns**

Shrewsbury and Telford Hospital NHS Trust did not routinely receive information about children from Powys where there were safeguarding concerns. Staff in the Emergency Departments or children's services were not alerted to 'at risk' children and young people and systems for establishing if a child was considered 'at risk' were not robust. Trust staff had tried to resolve this issue but relevant staff within Powys had not agreed to arrangements for alerts for 'at risk' children.

2 **Care of children at Royal Shrewsbury Hospital**

Several aspects of the care of children at Royal Shrewsbury Hospital between 10pm and 9am (12 noon on Saturday and Sunday) were of serious concern to reviewers:

a. A registered healthcare professional with advanced paediatric resuscitation and life support competences was not always available (see immediate risk: RSH Emergency Department section of this report)

b. An anaesthetist with advanced paediatric resuscitation and life support competences and experience of intubation of children was not always immediately available (see concern: Paediatric Anaesthesia section of this report)

A consultant paediatrician was on call for RSH at all times and the Trust was trying to mitigate the risks associated with the situation at RSH, including close working with the West Midlands Ambulance Service, clear pathways of care, scenario training, attendance of a PRH nurse if a paediatric emergency arose, rotation of some Emergency Department consultants between RSH and PRH, rotation of band 5 RSH nurses to PRH and one RSH consultant anaesthetist who undertook paediatric lists at PRH. Band 6 nurses from RSH

[1] **Immediate risk response:** This issue was resolved on the evening of the 12th May following the feedback session at the Critically Ill and Injured Children review. The oxygen and suction consumables are now attached at point of source. Ward staff have been informed via the established communication folder and the Matron for Children's Services will introduce a bed space checklist by 12th June 2015.
WMQRS response: These actions, if fully implemented, address the immediate risk identified.

did not, however, rotate to PRH, some Emergency Department consultants did not rotate and some anaesthetists had not regularly undertaken paediatric lists. Staff confidence in care of unstable children will reduce if they are not regularly involved in providing care for children. This will affect the medium-term sustainability of the arrangements.

3 Consultant surgeons were covering both hospital sites at night.

Further Consideration

1 Children clearly had a high priority within children's services. Care of children did not appear to be a priority in other services within the Trust where children were seen. A Trust paediatric Stakeholder Group was due to meet for the first time shortly after the review visit and reviewers encouraged involvement and engagement of all Trust services which provided care for children and young people. Regular reporting from the Stakeholder Group to the Trust Board may also be helpful.

2 Information for parents was available but relatively little information in a format suitable for children and young people. Reviewers suggested that further work with the Shropshire Young Health Champions may be helpful in developing this information.

3 The Trust resuscitation training team comprised four Resuscitation Training Officers (RTOs) who were keen to improve resuscitation training across the Trust. They had no space allocated for their work and no administrative support. As a result, RTOs were having to spend time on administrative work to the detriment of time to provide training. Good records of which staff had completed resuscitation training were not available, and Trust staff were attending external courses when the training could have been provided 'in house'.

4 Some of the patients' notes seen by reviewers had loose sheets of paper inside notes, did not have a sticker or other identification on every page, for example GMC (General Medical Council) number, and it was not always clear which member of staff had made entries in the notes. Notes were, however, written in black ink, dates and times were recorded and notes were filed in a clearly marked paediatric section.

5 An acute pain service for children was not available at either hospital site, in particular, at Princess Royal Hospital. Reviewers suggested that the development of an acute pain service would help to support the in-patient provision on that site.

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EMERGENCY DEPARTMENTS

PRINCESS ROYAL HOSPITAL

General Comments and Achievements: See Trust-wide section of this report

Good Practice: See Trust-wide section of this report.

Immediate Risks

1 **Process from arrival to triage**[2]

Patients arriving at the Emergency Department took either a numbered ticket or a card (when the ticket machine was not working) and waited in the waiting area until called for triage. Patients were not 'booked in' until after triage. No receptionist or other member of staff had an overview of the waiting area. The

[2] **Immediate risk response:** The triage process at the Princess Royal Hospital has now been changed so that it mirrors that of the Emergency Department at the Royal Shrewsbury Hospital. This change had already been planned for the summer months, once building work in the department to improve the flow for patients had been completed.
WMQRS response: The response addresses the risk identified.

condition of both children and adults could therefore deteriorate between arrival and triage without this being noticed by a member of staff.

Concerns

1 **Resuscitation and Life Support Training**

Resuscitation training records for medical and nursing staff were not available and it was not clear whether staff had undertaken appropriate training in paediatric resuscitation and life support. This issue would have been classified as an 'immediate risk to clinical safety and clinical outcomes' if support from paediatric staff with appropriate training had not been available.

2 **Environment**

The environment in the Emergency Department was not child-friendly. Children did not wait separately from adult patients before triage. A small paediatric waiting area was then available for children aged under 13 but this had few toys and games for children. One cubicle in the Emergency Department was set aside for children but children had to go past adult patients to get to this cubicle. If more than one child was being cared for in the Department then adult cubicles were used. One of the resuscitation trolleys was used for children but with no separation from adult patients.

Further Consideration

1 The triage and 'GP at the door' system operating at the time of the review visit did not make good use of staff time. Two nurses sat in the same room and undertook triage. A GP sat in a room behind the nurses and saw patients who were considered appropriate. Three staff were therefore taken up by triage and primary care patients (while no-one was observing patients before triage).

ROYAL SHREWSBURY HOSPITAL

General Comments and Achievements: See Trust-wide section of this report

Good Practice

1 The children's waiting area in the Emergency Department was well-designed and child-friendly, including a 'happy memories' board where children could provide feedback on their experience of the service.

2 See also Trust-wide section of this report.

Immediate Risks

1 **Availability of staff with advanced paediatric resuscitation and life support training and level 1 RCPCH competences**

At the time of the review, only two of the seven middle grade doctors in the Emergency Department had up to date advanced paediatric resuscitation and life support training and only three of the six Emergency Department consultants. Paediatric staff were available 9am to 10pm Monday to Friday and 12 noon to 10pm on Saturdays and Sundays. A child could arrive and need resuscitation outside of these hours and a member of staff with appropriate competences to lead the resuscitation would not always be available.[3]

[3] **Immediate risk response:** Consultants in the Emergency Department have committed to refreshing their paediatric life support training. In addition, as for the middle-grade doctors, the Consultants will take part in the multi-disciplinary scenario training to maintain their clinical skills.
WMQRS response: These actions address the risk identified when advanced paediatric life support training and multi-disciplinary scenario training have been completed.

A registered healthcare professional with level 1 Royal College of Paediatric and Child Health competences was not always available at Royal Shrewsbury Hospital after 10.00pm when paediatric staff were not on site. Some locum doctors had these competences but this was not guaranteed.[4]

Concerns: See Trust-wide section of this report

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CHILDREN'S ASSESSMENT AND IN-PATIENT UNITS

PRINCESS ROYAL HOSPITAL (CHILDREN'S ASSESSMENT AND IN-PATIENT UNITS)

General Comments and Achievements

Facilities in the new unit were spacious and bright with a well-stocked play room and school room. A lounge for young people was being developed in liaison with service users. Consultants were available on site until 9.30pm Monday to Friday and 9am to 3pm on Saturdays and Sundays. See also Trust-wide section of this report.

Good Practice: See Trust-wide section of this report

Immediate Risks: See Trust-wide section of this report

Concerns:

1 **Middle-grade doctor availability at night**

After 11pm, middle-grade doctors on the paediatric rota were covering the neonatal unit serving a maternity department of over 5000 births, children's assessment unit, in-patient paediatric wards and the Emergency Department. Reviewers considered that this arrangement had real potential for the middle-grade doctor not to be available within five minutes because they were busy elsewhere, and because of the lack of evidence of advanced paediatric resuscitation and life support training among doctors in the Emergency Department

2 See Trust-wide section of this report

Further Consideration:

1 High dependency care was being provided but was not yet commissioned. Reviewers suggested that the Trust and local commissioners actively engage with NHS England commissioners of specialised services about formal commissioning of levels 1 and 2 paediatric critical care at Princess Royal Hospital.

[4] **Immediate risk response:** The doctors working in the Emergency Department will ensure that they complete and maintain paediatric life-support training appropriate to being the "first responders" to a critically ill or critically injured child. They will be supported in this by the resident and on call Anaesthetist(s) who will be involved in their own programme of paediatric life-support training and by the on call Paediatrician(s). In line with an assessment made by a visiting team from the Royal College of Paediatrics and Child Health, prior to the completion of the reconfiguration of services for Children, during "out of hours periods", in the short term there will not be resident on call Paediatricians or other staff with level 1 RCPCH competences. On the limited occasions that seriously ill children do present, "out of hours" at RSH, they are cared for by the Emergency Department team – who will have updated their Paediatric Life Support training; the resident Anaesthetist team – who will have updated their Paediatric Life Support training; the on call Consultant Paediatrician and Consultant Anaesthetist.
WMQRS response: Although the number of children presenting to the Royal Shrewsbury Hospital since the reorganisation has reduced, the risk is still present for those children who may attend when a member of staff with level 1 RCPH competences is not available.

2 Opportunities for integration with community children's teams did not appear to be being taken. Reviewers suggested that greater integration may help to improve care for children and reduce lengths of stay in hospital.

ROYAL SHREWSBURY HOSPITAL (CHILDREN'S ASSESSMENT UNIT)

General Comments and Achievements

The Children's Assessment Unit at Royal Shrewsbury Hospital opened in September 2014 but was closed between January and March 2015 due to demand for adult acute admissions. A weekday clinic in the out-patient department was used during this time for routine paediatric activity. The service had moved to a new location shortly before the review visit.

Good Practice: See Trust-wide section of this report

Immediate Risks: See Trust-wide section of this report

Concerns: See Trust-wide section of this report

Further Consideration

1 The environment within the Children's Assessment Unit may benefit from review. Reviewers commented that it could be brighter and have more displays and information, including feedback from young people.

2 A review of the Children's Assessment Unit at Royal Shrewsbury Hospital by commissioners was planned. Reviewers commented that the issues relating to the care of children at Royal Shrewsbury Hospital identified above would affect significantly more children if a Children's Assessment Unit was not available on site. There may be the potential for the unit to undertake more routine paediatric activity for local children and young people in order to improve its viability.

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PAEDIATRIC ANAESTHESIA AND DAY SURGERY UNIT

General Comments and Achievements

Since September 2014 most paediatric surgery and anaesthesia took place at Princess Royal Hospital, Telford. Time-critical (life, limb, eye-saving) surgery still took place at Royal Shrewsbury Hospital plus some emergency ophthalmic surgery. 24/7 anaesthetic cover was available on both sites with a resident Tier 2 anaesthetist and an on-call consultant able to attend within 30 minutes. Children and young people could be admitted to the general intensive care unit at Princess Royal Hospital with support from paediatric services. At Royal Shrewsbury Hospital children and young people were admitted to the general intensive care unit only in exceptional circumstances which were individually risk-assessed and discussed with the KIDS Specialist Paediatric Transport Service.

Plans had been developed for theatre staff from Royal Shrewsbury Hospital to spend time at Princess Royal Hospital in order to maintain their skills in care of children in an emergency, including super-numerary lists and simulation training. This had been partially implemented. Royal Shrewsbury Hospital anaesthetists were encouraged to take part in simulation training.

Good Practice

1 Anaesthetic guidelines were clear, comprehensive and easily available to all staff.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Royal Shrewsbury Hospital: Anaesthetic staff**

At the time of the review, Royal Shrewsbury Hospital anaesthetic medical staff with emergency or elective responsibility for the care of children did not all have up to date competences in advanced paediatric

resuscitation and life support. Plans were in place to address this issue. All anaesthetists had received a letter from the Trust explaining that they should be competent in the management of paediatric emergencies and suggestions on how this could be achieved.

2 **Day Surgery Unit environment**

Child and adult patients were not separate on the Day Surgery Unit. Children and young people were admitted to a separate bay which had visual, but not sound, separation from adult patients. Children had to go past adult patients on their way to theatre or if they needed to use the toilet, which was across the corridor. Decoration in the bay was not child-friendly and limited toys and books were available.

Further Consideration

1 The Trust did not have an acute pain service, although clear pain-management protocols were available. Reviewers suggested that consideration should be given to introducing an acute pain service, especially if the complexity of surgery undertaken within the Trust were it increase.

2 The on-call surgeon covered both Princess Royal Hospital and Royal Shrewsbury Hospital outside normal working hours. Reviewers did not consider that this arrangement would be sustainable in the longer-term.

3 The recovery areas on both sites were not child-friendly and children were not separate from adult patients. One recovery bay was identified for the care of children.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Paul Duflot	Ward Manager	Sandwell & West Birmingham Hospitals NHS Trust
Dr Semiu Giwa	Consultant Emergency Medicine	The Royal Wolverhampton NHS Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall CCG
Dr Reinout Mildner	Consultant Paediatric Intensivist	Birmingham Children's Hospital NHS Foundation Trust
Dr Titus Ninan	Consultant Paediatrician	Heart of England NHS Foundation Trust
Dana Picken	Modern Matron, Paediatrics	Worcestershire Acute Hospitals NHS Trust
Pamela Smith	Deputy Director of Nursing	The Dudley Group NHS Foundation Trust
Dr Sue Smith	Consultant Anaesthetist and Divisional Medical Director	The Royal Wolverhampton NHS Trust
Brenda Taylor	Senior Sister	Walsall Healthcare NHS Trust

Observer

Kate Branchett	Patient Voice and Insight Lead	West Midlands Strategic Clinical Network and Senate

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE 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 varies 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
Review of the Care of Critically Ill and Critically Injured Children			
Trust-wide	9	8	89
Emergency Department	90	57	63
Princess Royal Hospital Telford	(45)	(29)	(64)
Royal Shrewsbury Hospital	(45)	(28)	(62)
Children's Assessment and In-patient Units	96	71	74
Princess Royal Hospital Telford: Children's Assessment & In-Patient Units	(54)	(39)	(72)
Royal Shrewsbury Hospital: Children's Assessment Unit	(42)	(32)	(76)
Day Surgery	34	24	71
Paediatric Anaesthesia	21	15	71
Total	**250**	**175**	**70**

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

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ACUTE TRUST-WIDE

Ref	Quality Standard	Met? Y/N	Reviewer Comments
PC-201	**Board-level lead for children** A Board-level lead for children's services should be identified.	Y	The Trust Director of Nursing was the Board-level lead for children's services and also chair the Patient Involvement Group.
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	
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.	N/A	
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 UHCW CIC appendix D1 20140211emergency surgery on children (QS PG-503).	Y	The document available online may not be the final version. It appeared incomplete and had no exclusion criteria for ophthalmology.

Ref	Quality Standard	Met? Y/N	Reviewer 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	The Trust was clear about the services provided although an acute pain service was not available at either hospital site. The Children's Assessment Unit at Royal Shrewsbury Hospital was not available 24/7.
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.	Y	
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 with trauma were seen at Royal Shrewsbury Hospital, including children who needed to 'stop off' on the way to Birmingham Children's Hospital but the hospital did not have a high dependency service or Paediatric Intensive Care Unit on the same hospital site.
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 Trust Children's Board was scheduled to meet for the first time five days after the review visit.

Ref	Quality Standard	Met? Y/N	Reviewer 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	
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	A policy was in place and information leaflets for parents were available.

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Emergency Department

PRH: Princess Royal Hospital **RSH**: Royal Shrewsbury Hospital

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer 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 f. 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	PRH: See main report.
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	Available leaflets were not child friendly.

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer 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-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	N	No written policy was available but parents were advised to contact PALS (Patient Advice and Liaison Service) if they needed financial support.
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	N	N	Feedback mechanisms were not evident at PRH. It was not clear if children and families were involved in decisions about the organisation of services on either site.
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	
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.	Y	N	PRH: This was met through availability of paediatric and anaesthetic staff. RSH: See main report.

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer 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	N	Not all medical and clinical staff had up to date paediatric resuscitation training. PRH: Evidence was not available. RSH: 33/41 nursing staff had appropriate resuscitation training. See main report in relation to medical staff.
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.	N	N	It was not possible to ensure that a clinician with advanced resuscitation was always on duty as there was a reliance on locum middle grades for weekend and night shifts.
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	N	A clinician with level 1 competences was not always on duty at Royal Shrewsbury Hospital after 22.00 hours until 9.00am on weekdays and 12.00pm at weekends. A clinician with level 1 competences was sometimes available but this was not guaranteed, especially because of the heavy reliance on locum doctors.
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 PRH two paediatric nurses were available and a third nurse was on a conversion course at the time of the review. At RSH three paediatric nurses were available and there was access to ANP 7/7 until 22.00. There was a lack of clarity around the flexing of staffing levels to meet dependency of patients. A Trust escalation policy was available.

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer 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.	N	N	There were insufficient children's trained nurses to cover the departments 24/7.
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.	N	N	At RSH 33/41 nursing staff had appropriate resuscitation training. Evidence was not available for PRH.
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N	N	PRH: Support for play was not available 7/7 from appropriately qualified play specialists. RSH: Support for play was not available. The Trust had plans to introduce this through the PRH play specialists.
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	PRH: Surgeons were not always available. RSH: 'c' was not met when paediatric staff were not on site.
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	

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer Comments
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	
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.	Y	Y	Monthly scenario training was in place. See, however, main report in relation to medium-term problems.
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	No policy was 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	Emergency Department staff from both sites did not regularly attend the Trust safeguarding meetings.
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	
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	Appropriate critical care support was not available at RSH.

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer Comments
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	The equipment trays at PRH were good although there was no list available. A housekeeper had responsibility for ensuring equipment was all within date.
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.	N	Y	PRH: See main report. Arrangements at RSH were good.
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	Y	Y	
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	
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 Standard	Met? PRH	Met? RSH	Reviewer 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	
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.	Y	Y	

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer 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	
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.	N	N	The organ donation policy expired in 2013.
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 Standard	Met? PRH	Met? RSH	Reviewer Comments
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	The Trauma protocol was not paediatric-specific.
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	Y	Y	

Ref	Quality Standard	Met? PRH	Met? RSH	Reviewer Comments
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	Arrangements for review by a neuro-radiologist could be clearer. Reviewers were told that links would be made with Birmingham Children's Hospital radiologists but this was not clear in the policy.
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'.	N	N	Multi-disciplinary arrangements for review and learning were not yet in place. Medical meetings were held.
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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CHILDREN'S ASSESSMENT & IN-PATIENT UNITS

PRH: Princess Royal Hospital **RSH**: Royal Shrewsbury Hospital

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer 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 f. Information for parents about these services should also be available.	Y	Y	All services were available.
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	PRH had a large play-room for younger children and a lounge for young people was being developed. At RSH the environment was clean but could have been more welcoming.
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	One parent could stay overnight at PRH. RSH had fewer facilities for parents as the unit was not open overnight.
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	N	N	Little information for children and young people was available on both sites.
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	Information for parents was available on both sites. Leaflets were available and further information could be printed. The information did not mention the patient group or other opportunities for involvement in improving services.
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	

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer Comments
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	N	No written policy was available but parents were advised to contact PALS (Patient Advice & Liaison Service) if they needed financial support.
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	Information could be printed from the Trust intranet if required. This facility was not widely advertised to parents.
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/A	At PRH a family room was available on the ward and a restaurant and coffee shop within the hospital site. There was also a kitchen and designated toilet for parents. This Quality Standard was not applicable at RSH but parents could be on the unit for quite a long time and further consideration of facilities for parents may be helpful.
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	N/A	Fold-out beds were available in each bed space at PRH.
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	N/A	Accommodation away from the ward at PRH was not available.
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	Feedback mechanisms were in place. There may be opportunities to develop these further.

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer 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	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	
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.	Y	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.	N	N	It was not clear that Tier 1 doctors had appropriate resuscitation training.
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	N	There was no clinician with level 1 competences on duty at Royal Shrewsbury Hospital after 22.00 hours until 9.00am on weekdays and 12.00pm at weekends.

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer Comments
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	Competence packages had been introduced but were not yet fully embedded. These were being reviewed at personal development meetings.
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	At PRH staff worked flexibly across the on-site services.
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.	N	N	Not all nurses had appropriate paediatric resuscitation training but the Trust were aware of this and had plans in place.
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N	N	Support for play was not available 7/7 from appropriately qualified play specialists.
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.	N	N/A	No lead nurse for high dependency care was identified. It was not clear that the consultant had undertaken appropriate continuing professional development.
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	N/A	

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer Comments
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.	N	N/A	Training and competency packages were under development at the time of the review.
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.	N	N/A	Staffing levels were appropriate within the ward environment and a supervisory nurse was available on each shift. Staffing of children needing high dependency care had not yet been audited.
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	N/A	Some staff had not yet received tracheostomy training.
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/A	Evidence of physiotherapy and pharmacy staff with job planned time for work with children needing high dependency care was not available.
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	No policy was 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	

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer 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	Surgical specialties had a single consultant covering two sites.
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.	N	N	See main report immediate risk relating to oxygen and suction equipment. Resuscitation rooms were spacious. The tagging and sealing of resuscitation bags and equipment was under review.
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	Bays were of a good size and all appropriate monitoring equipment was available.
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	PEWS were used for triage within 15 minutes.
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	Patient pathways were available including movement between sites.

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer 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	Y	
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	
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	Resuscitation and stabilisation protocols were included in the patient pathways.
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	

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer Comments
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	
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.	Y	Y	
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	'Grab bags' were available on both sites.

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer 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.	N	N	The organ donation policy expired in 2013.
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	
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	N/A	Children on long-term ventilation were not admitted.
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	Y	N/A	
PQ-701	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS.	N	N/A	The Trust had plans to commence data collection.

Ref	Quality Standards	Met? PRH	Met? RSH	Reviewer Comments
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	A rolling programme of audit was in place and action plans arising from audits were available.
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	Joint monthly meetings were in place as well as paediatric stakeholder meetings.
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

Ref	Quality Standards	Met? Y/N	Reviewer 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.	N	See main report.

Ref	Quality Standards	Met? Y/N	Reviewer 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	Information was available for parents but not for children.
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	
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	Compliance based on self-assessment.
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	No written policy was available but parents were advised to contact PALS (Patient Advice & Liaison Service) if they needed financial support.
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	N	'a' was met but there was no evidence of involvement of children and families in decisions about the organisation of the service.
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	

Ref	Quality Standards	Met? Y/N	Reviewer 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.	N	See main report: paediatric anaesthesia.
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	Paediatric medical staff were based nearby and would attend for a paediatric resuscitation.
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	
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? Y/N	Reviewer 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.	N	Not all nurses had appropriate paediatric resuscitation training but the Trust were aware of this and had plans in place.
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N	Support for play was available from paediatric wards if required. The facilities for children were not child-friendly and reviewers suggested that involving play specialists may be helpful in addressing this issue.
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	No policy was 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	
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
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	
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.	N/A	The unit took only elective admissions.
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	
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	
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.	N	PEWS was used on the paediatric wards and in the Emergency Department but not on the Day Surgery Unit.
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	

Ref	Quality Standards	Met? Y/N	Reviewer 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	
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	
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.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer 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	
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.	N/A	
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.	N/A	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	N	Reviewers did not see evidence of audits involving day surgery.
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.	N/A	National audit programmes covering day surgery were not available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
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	
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 Standard	Met? Y/N	Reviewer 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	N	'a', 'b' and 'c' were met. 'd' was not met on either site. Clear pain management protocols were, however, available online.
PG-102	**Information on anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	Y	Information was available at PRH. Only time-critical emergency surgery (life, limb or eye-saving) and some emergency ophthalmic surgery was undertaken at RSH. Reviewers suggested that appropriate information at RSH should be available.
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	Mechanisms for receiving feedback from children and families and involving them in decisions were in place on both sites.
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	

Ref	Quality Standard	Met? Y/N	Reviewer Comments
PG-202	**GICU lead consultant** A nominated lead intensive care consultant should be responsible for Intensive Care Unit policies and procedures relating to children.	Y	This Quality Standard was met at PRH and was not applicable at RSH.
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.	Y	This Quality Standard was met at PRH and was not applicable at RSH.
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	This Quality Standard was met at PRH but not at RSH (see main report).
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	Some staff had undertaken PILS (Paediatric Intermediate Life Support) training. Plans for rotation of staff through paediatric lists at PRH were being developed but had not been fully implemented at the time of the review.
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.	N	Staff with paediatric experience were not always available at PRH. Staff at RSH were undertaking PILS (Paediatric Intermediate Life Support) training in order to mitigate the lack of regular paediatric experience.
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	N	See main report.
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.	N	Children were admitted to a separate bay on the day surgery unit. See main report.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
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	
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.	Y	
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	Protocols were clear, well-presented and comprehensive.
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	Y	
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	

Ref	Quality Standard	Met? Y/N	Reviewer Comments
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.	Y	Data were supplied to ICNARC (Intensive Care National Audit and Research Centre).

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