WM QRS West Midlands Quality Review Service

NHS

Care of Critically Ill & Critically Injured Children Quality Review Visit

University Hospitals of North Midlands NHS Trust – County Hospital

Visit Date: 6th July 2016 Report Date: October 2016





UKAS INSPECTION 8831

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INTRODUCTION

This report presents the findings of the review of Care of Critically Ill & Critically Injured Children Quality Review Visit at County Hospital, University Hospitals of North Midlands NHS Trust that took place on 6th July 2016. The purpose of the visit was to review compliance with the West Midlands Quality Review Service (WMQRS) Quality Standards for the Care of Critically Ill and Critically Injured Children Version 5.

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 County Hospital, University Hospitals of North Midlands 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:

- University Hospitals of North Midlands NHS Trust
- NHS Stafford and Surrounds Clinical Commissioning Group
- NHS Cannock Chase Clinical Commissioning Group
- NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
- NHS Stoke on Trent Clinical Commissioning Group
- NHS North Staffordshire 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 commissioner in relation to this report is NHS Stafford and Surrounds Clinical Commissioning Group.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of County Hospital, University Hospitals of North Midlands NHS Trust and Staffordshire CCGs 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.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between 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 Return to *Index*

VISIT FINDINGS

CHILDREN'S EMERGENCY CENTRE

General Comments and Achievements

The Children's Emergency Centre at County Hospital, Stafford had been functioning since April 2015. The service was situated within the Emergency Department and had a waiting area, triage room, three cubicles, two assessment beds and a treatment room. The Children's Emergency Centre was made up of the Children's Emergency Department and the Children's Assessment Area. The service functioned from 8am to 10pm daily with criteria for children who would be seen by the service. Approximately 30 children per day attended the Children's Emergency Centre. Patients were either treated in the Children's Emergency Centre, transferred to the Royal Stoke Hospital or seen the same day or next day in a 'Rapid Access' paediatric clinic which had two 'slots' for urgent referrals from GPs or the Children's Emergency Centre. Children could also be admitted to the Children's Assessment Area, for example, for observation, investigations or initial treatment. The Children's Emergency Centre was under the managerial and governance responsibility of the Emergency Department, which was part of the Medicine Directorate.

The Children's Emergency Centre provided a pleasant, clean environment for the care of children and their families. Facilities were appropriate and staff were very friendly and welcoming. Families were offered sandwiches and squash while they were waiting. Good general health information was available and a good feedback form about children's experience of the service was in use. The resuscitation trolley was appropriately stocked and checked regularly.

Nursing staff had worked hard to ensure they had appropriate competences for their work in the Children's Emergency Centre, including undertaking advanced paediatric life support (APLS) training and additional training in the care of children with minor injuries. Two registered children's nurses, one of which would have APLS training, were on duty on almost all shifts. Emergency Department adult nurses had also undertaken Paediatric Intermediate Life Support (PILS) training and covered occasional shifts in the Children's Emergency Centre.

Immediate Risks

The Children's Emergency Centre was considered an immediate risk to clinical safety and clinical outcomes for the following reasons:

1 A member of staff with Level 1 Royal College of Paediatrics and Child Health (RCPCH) competences was not available in the Children's Emergency Centre at any time (except for occasional shifts covered by staff from Royal Stoke Hospital). Assessments and management by an appropriately qualified member of staff were therefore not available. Reviewers looked at the management of five individual cases, three of which, in their opinion, were not managed appropriately with potentially life-threatening consequences.

   A consultant paediatrician was supposed to be available on site running a 'Rapid Access' clinic between 2pm and 6pm on weekdays and between 3pm and 6pm at weekends. These clinics were running only approximately 50% of the time and, even when running, the consultant did not attend the Children's Emergency Centre or have input to the care of children there.

2 An appropriately staffed paediatric resuscitation team was not available. The following staff should be available to support a paediatric resuscitation:

   a. A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least level 1 RCPCH (or equivalent) competences

   b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences

c. An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management

In practice, paediatric resuscitations would be attended by an Emergency Department consultant or middle grade doctor, a Children's Emergency Centre nurse and, possibly an anaesthetist. Reviewers were told that all 20 consultants working in across the Trusts two Emergency Departments had APLS training but the evidence provided had a training date recorded for only three of eight consultants. Nearly all of the middle grade doctors were locums (7.5 out of eight posts); information on resuscitation training was available for only one middle grade doctor who was recorded as having basic paediatric life support training.

The second registered healthcare professional role on the paediatric resuscitation team would be taken by a nurse from the Children's Emergency Centre. These nurses had completed appropriate training but were making little use of the competences gained and may therefore not feel confident in an emergency.

There was no evidence that on-site anaesthetists had up to date competences in the care of children and the two anaesthetists who met the visiting team were clear that they did not have appropriate up to date competences. Due to changes in working patterns, anaesthetists who had previously worked at Royal Stoke Hospital, often with no paediatric involvement for many years, were now working at the County Hospital. There was no policy on accessing 'difficult airway' support and 'difficult airway' equipment was stored in theatres, although children did not go to theatres at the County Hospital. It was not clear that appropriate equipment for difficult airway management in a child was available.

3 The service was not prepared to undertake a time-critical transfer, should this be required. As described above, appropriate staff to accompany a time-critical transfer were not usually available and reviewers were given different views about who would take this role. Emergency Department staff said that an anaesthetist would accompany a transfer but the anaesthetists who met the visiting team were not expecting to take this responsibility. A transfer policy was in draft form but had not yet been agreed. Some useful appendices had been developed for this policy but these were not kept with the policy and it was not clear whether or not they were in use. A 'grab bag' with appropriate drugs and equipment was not available for use in a time-critical transfer. In general, staff did not appear aware that, although rarely, they may be required to undertake a time-critical transfer.

4 The Safeguarding Policy was not clear and evidence that appropriate staff had competences in recognition and referral of children with safeguarding concerns was not available. Reviewers considered that, as Children Emergency Centre staff were working with children, this level of training would be appropriate.

5 Reviewers were told by some staff that ambulances did not bring children to the Children's Emergency Centre but this policy was not clearly documented (it appeared as a draft alteration to the Children's Emergency Centre operational policy) and 10 children had been brought by ambulance between June 15 and April 16. Some staff thought that children were brought by ambulance. Reviewers were also told that if parents did not want their child taken to Stoke then they were offered the option to get out of the ambulance near the County Hospital and walk to the County Hospital Children's Emergency Centre. It was not clear that these children had been assessed as appropriate for care at the Children's Emergency Centre.

6 Arrangements for prioritising the needs of the sickest patients were not robust. Initial assessment was undertaken using the Manchester triage system and a priority level was allocated. This priority level was recorded on the Emergency Department's computer system but was not visible to medical staff unless their screen was set to 'all areas' and 'priority view' settings. No medical staff had responsibility allocated for the Children's Emergency Centre and, at the time of the review visit, computer screens were usually set to view the patients in specific areas (rather than the 'all areas' setting). As a result, medical staff could be caring for a lower priority patient in another area, unaware that a higher priority child was in the Children's Emergency Centre. Nursing staff in the Children's Emergency Centre had no guidance or systems to enable and empower them to call a doctor to see a child and reviewers were told that medical staff sometimes did not respond when requested. Patient feedback also described long waits to be seen by a doctor.

7 A robust system to provide early warning of the deterioration of a child was not in place. Initial observations were taken and a Modified Early Warning Score (MEWS) calculated by the computer and the information then put onto a Paediatric Early Warning System (PEWS) chart, with the potential for error and confusion. There was no policy available to reviewers on how often observations and PEWS scores should be repeated and the length of time between observations was considered inappropriately long in one of the cases seen by reviewers. There was also no clear PEWS-based escalation policy, tailored to the staffing available at the County Hospital.

8 Children admitted to the Assessment Area were not visible on the computerised screens of Emergency Department patients and medical responsibility for these patients was not clear. The Children's Emergency Centre operational policy was due for review in October 2015 and criteria for admission to the Children's Assessment Area did not appear to reflect what was happening in practice. The operational policy stated that children could stay in the Assessment Area for up to eight hours.

9 Guidelines for the care of children with asthma were not being followed. Reviewers were told that Partners in Paediatrics (PiP) or other nationally recognised guidelines were used. A Trust poster titled "Child Health: Key Prescribing Messages" recommended dosage of 0.5mg per kg of prednisolone, half the level recommended in the PiP guidelines. This situation had the potential for confusion and inappropriate treatment.

10 Arrangements for review of children prior to discharge were not clear. Reviewers were told that children aged under a year should be reviewed by a consultant prior to discharge but this policy was not documented. It appeared possible for an FY2 doctor to discharge a child with only informal system if the Emergency Department consultants were worried about the decisions being made by individual doctors.

11 Governance responsibility for the Children's Emergency Centre did not appear to be functioning effectively. Incidents were recorded on the Datix system but these were not always discussed. The Emergency Department held mortality and morbidity review meetings, but these meetings did not include staff from the Children's Emergency Centre. Robust mechanisms for involvement of consultant paediatricians in training, guideline development, audit and review and learning were not evident. It was not clear that staff of the main Emergency Department and Medicine Directorate had appropriate understanding of the needs of children and the risks inherent in caring for children. This view was reinforced by comments, when asked about deteriorating or critically ill children, that "it doesn't happen here".

Further Consideration

1 Nurse staffing levels for the Children's Emergency Centre were highest between 2pm and 6pm when four registered nurses and two healthcare assistants were on duty. Between 8am and 2pm and between 6pm and 10pm staffing was half this level. The distribution of staff through the day may benefit from review, especially as peak attendance times were reported as between 6pm and 10pm.

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COMMISSIONING

The commissioner who met the visiting team did not have responsibility for commissioning services for children. Reviewers did not see evidence of appropriate monitoring of the Children's Emergency Centre service by commissioners.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Emma Bull	KIDS Lead Nurse, KIDS Intensive Care and Decision Support	Birmingham Children's Hospital NHS Foundation Trust
Dr Jayne Clarke	Consultant Paediatrician	Wye Valley NHS Trust
Lindsey Hodges	User Representative	Not applicable
Zoe Morris	User Representative	Not applicable
Shiela Pantrini	Senior Paediatric Advanced Clinical Practitioner/Educator	Heart of England NHS Foundation Trust

WMQRS Team

Jane Eminson	Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant 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
Trust-Wide	10	3	30
Children's Emergency Centre	34	12	35
Commissioning	5	1	20
Total	49	16	33

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TRUST-WIDE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-201	**Board-Level Lead for Children** A Board-level lead for children's services should be identified.	Y	
PC-202	**Clinical Leads** The Board-level lead for children's services should ensure that the following leads for the care of children have been identified: a. Lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Lead consultant for paediatric critical care c. Lead consultant for surgery in children (if applicable) d. Lead consultant for trauma in children (if applicable) e. Lead anaesthetist for children (QS PG-201) f. Lead anaesthetist for paediatric critical care (QS PG-202) g. Lead GICU consultant for children (QS PG-203) (if applicable) h. Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS PT-201) (if applicable) i. Lead consultant and lead nurse and for safeguarding children j. Lead allied health professional for the care of critically ill children	Y	
PC-203	**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 Lead for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children and clinical governance issues relating to children should be clear.	N	A group involving the nominated leads and resuscitation office was not yet in place.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-204	**Paediatric Resuscitation Team** A paediatric resuscitation team should be immediately available at all times, comprising at least three people: a. A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least Level 1 RCPCH (or equivalent) competences (QS PM-203) b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences c. An anaesthetist or other doctor with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management	N	See main report.
PC-205	**Consultant Anaesthetist 24 Hour Cover** A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7.	N	See main report.
PC-206	**Other Clinical Areas** Staff in other clinical areas where children may be critically ill, such as imaging and paediatric out-patient departments, should have basic paediatric resuscitation and life support training.	N	Reviewers were told that Emergency Department staff had PILS (Paediatric Immediate Life Support) training but evidence was not available to confirm this. It was not clear if radiology and paediatric outpatient department staff had appropriate training.
PC-401	**Paediatric Resuscitation Team – Equipment** The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy.	Y	
PC-501	**Resuscitation and Stabilisation** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child	N	A protocol was available but did not cover arrangement for accessing support for difficult airway management.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-502	**Surgery and Anaesthesia Criteria** Trust-Wide guidelines on criteria for surgery and anaesthesia for children should be in use covering: a. Elective and emergency surgical procedures undertaken on children of different ages b. Day case criteria c. Non-surgical procedures requiring anaesthesia or conscious sedation	N/A	
PC-598	**Trust-Wide Guidelines** The following Trust-Wide guidelines should be in use: a. Consent b. Organ and tissue donation c. Palliative care d. Bereavement e. Staff acting outside their area of competence covering: i. Exceptional circumstances when this may occur ii. Staff responsibilities iii. Reporting of event as an untoward clinical incident iv. Support for staff	N	'e' was not yet in place. All other guidance were in place. 'c': The service did not provide ongoing care for children.
PC-602	**Paediatric Critical Care Operational Delivery Network Involvement** At least one representative from the Trust should attend each meeting of the Paediatric Critical Care Operational Delivery Network. Information about the work of the network should be disseminated to all staff involved in the provision of critical care for children.	N	Representatives from the Children's Emergency Centre did not attend the network meetings and evidence of dissemination of information about the work of the network was not disseminated to them.

CHILDREN'S EMERGENCY CENTRE

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-101	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.	Y	Reviewers also noted the feedback from patients about décor on ceilings and access to Wi-Fi. The facilities were better equipped for younger children than for adolescents.
PM-102	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child	Y	
PM-103	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available.	N	Most information in the Children's Emergency Centre was not appropriate for younger children, apart from an asthma leaflet. Some information on the wall was age-appropriate. Information for parents was in place. The TV screen provided some information about the service and what to expect. Reviewers suggested that a 'welcome' leaflet may be helpful. The Children's Emergency Centre used Cheethams information booklets but this information referred children to out of hours services in North Staffordshire and not those available locally.

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-104	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations	N	'd' was not available easily although staff would arrange an appointment for psychological support. Information on financial support was not available and arrangements for providing information for parents whose children were admitted to the Royal Stoke Hospital was not clearly available. 'e': information was not easily accessible although reviewers were told that staff would offer refreshments.
PM-196	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details	Y	The information for parents were comprehensive and provided clear advice on what to expect and when to seek further help.
PM-197	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services	Y	

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-199	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families	N	The style of the feedback form was very clear and covered a range of questions including whether information had been given and was understood. 'Tops and Pants' clothes line was also in the department for children and young people to leave comments. Changes made as a result were less clear and were not displayed. The PALS (Patient Advice and Liaison Service) and patient experience lead said that changes were displayed in other areas.
PM-201	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.	Y	
PM-202	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children	N	A consultant was always on site but evidence seen by reviewers showed that only 3 out of 8 consultants had up to date Advance Paediatric Life Support training.

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-203	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.	N	See main report.
PM-206	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS PM-208) and expected input to the paediatric resuscitation team (QS PC-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems	Y	Rotas for one week seen showed Band 6 Children's Emergency Centre nurses with Advanced Paediatric Life Support and Band 5 nurses with Paediatric Immediate Life Support on each shift. The evidence supplied in the case examples would suggest that the nurses although being exposed to potentially sick or deteriorating children were not utilising their skills in order to recognise these children.

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-207	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing 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. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area	Y	
PM-209	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7)	N	A play specialist was not available 7/7. Other staff to support play were also not available 7/7.

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-298	**Safeguarding Training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role, as agreed by the Trust and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the Trust and local Safeguarding Board	N	See main report.
PM-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
PM-301	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	N	CT scanning and ultrasound were not available on site. Children would be referred to Royal Stoke Hospital for these procedures.
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-402	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.	N	A 'grab bag' was not available for use with time-critical transfers.
PM-406	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.	Y	

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
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 for full assessment exceed 15 minutes.	N	See main report.
PM-502	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.	N	See main report. The Paediatric Early Warning System (PEWS) paper documentation had been adopted from the Royal Stoke Hospital and staff who met the reviewing team were told that a PEWS Policy including escalation existed. Reviewers were unable to find the policy on the Trust Intranet.
PM-503	**Resuscitation and Stabilisation** Trust-wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child	N	'b' was not met. Other aspects of the Quality Standard were met.
PM-504	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.	Y	

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-505	**Clinical Guidelines** The following clinical guidelines should be in use: **All:** a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable)	N	Partners in Paediatrics (PiP) guidelines were on the intranet but these were not followed in the cases histories seen reviewers.
PM-506	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained	Y	

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-507	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.	N	A draft policy was in the process of being ratified but would benefit from more detail about timescales for transfer and escalation.
PM-508	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: 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	N	A draft policy was in the process of being ratified. Reviewers commented that the appendices were held separately to the main policy in clinical areas.
PM-509	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS PM-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS PM-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer	N	As Quality Standard PM-508

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-598	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines (QS PC-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence	N	Guidelines on surgery and anaesthesia for children had not been followed in the case histories seen by the visiting team.
PM-601	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral g. Arrangements for admission within four hours of the decision to admit h. Types of patient admitted i. Review by a senior clinician within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge	N	'd' and 'e' were not covered by the policy. The policy was due for review in October 2015.

Ref	Quality Standards	Met? Y/N?	Reviewer Comments
PM-703	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS PM-500s) b. Participation in agreed national and network-wide audits c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations	N	Some audits had been undertaken but there was no evidence of completion of the audit cycle.
PM-704	**Key Performance Indicators** Key performance indicators should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Information was collected on initial treatment, time in the department and attendance rates, but there was no evidence that Key Performance Indicators were reviewed regularly with commissioners.
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	See main report
PM-799	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	N	Some documentation seen by reviewers did not comply with the Trust document control process.

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COMMISSIONING

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PZ-601	**Paediatric Critical Care Needs Assessment and Strategy** Commissioners should have an agreed paediatric critical care: a. Needs assessment b. Strategy for the development of services across the Paediatric Critical Care Operational Delivery Network	N	Reviewers did not see any evidence of compliance with commissioning Quality Standards.
PZ-602	**Commissioning: Urgent Care for Children** Urgent care for children from the network's population should be commissioned including: a. Emergency Centres b. Trauma services for children and their designation c. Children's Assessment Services	Y	
PZ-603	**Commissioning: Paediatric Critical Care** Paediatric critical care services for the network population should be commissioned including: a. Level 1 paediatric critical care service/s b. Level 2 paediatric critical care service/s c. Level 3 paediatric critical care services/s d. Specialist Paediatric Transport Service, including whether commissioned for aeromedical transfers e. Extracorporeal membrane oxygenation (ECMO) f. Services for children needing long-term ventilation g. Paediatric Critical Care Operational Delivery Network/s The specification for each service should cover: i. Inclusions and exclusions in terms of age and conditions of children for which the service is responsible ii. Interventions to be offered in each PCCU iii. Key performance indicators	N	Reviewers did not see any evidence of compliance with commissioning Quality Standards.
PZ-604	**Paediatric Critical Care Operational Delivery Network** Commissioners should agree the catchment population, organisations involved and host organisation for the Paediatric Critical Care Operational Delivery Network/s within the area for which they are responsible.	N	Reviewers did not see any evidence of compliance with commissioning Quality Standards.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PZ-701	**Paediatric Critical Care Quality Monitoring** Commissioners should monitor at least annually key performance indicators and aggregate data on activity and outcomes from each paediatric critical care service, including: **L3 PCCU**: All instances of average occupancy exceeding 85% for more than two successive months **SPTS**: Arrival at referring unit within three hours of the decision to transfer the child	N	Reviewers did not see any evidence of compliance with commissioning Quality Standards.

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