JOINT STATEMENT by the Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN), Royal College of Paediatrics and Child Health (RCPCH) and the College of Emergency Medicine (CEM) ON THE URGENT & EMERGENCY CARE OF CHILDREN AND YOUNG PEOPLE

Right care, right place, first time?

In children with a fever whose parents choose to consult the NHS, the median number of consultations is 3, with a range of 1-13. Most of the repeat contacts were initiated by the urgent care services themselves[1]

Definition of Urgent & Emergency Care

Urgent and emergency care (U&EC) constitutes the range of healthcare services available to children and young people (ChYP) who need medical advice, diagnosis and/or treatment quickly and unexpectedly. This includes ambulance services, NHS Direct/24, out-of-hours and urgent care services, and hospital Emergency Departments (ED).

Purpose of this document

The aim of this document is to set clear standards and guidance for service planning and commissioning of U&EC services to patients 0-16 years, in a local pathway model. Its production was stimulated by the major reforms of the NHS in England but the conclusions and advice apply to all four UK nations, not just England. It is linked with the RCPCH-led Intercollegiate "Standards for Children and Young People in Emergency Care Settings" 2011[2], and also to the RCGP Centre for Commissioning's all-age "Guidance for Commissioning Integrated Urgent and Emergency Care" 2011[3].

Context

[1] *To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature) research report*, DH (England) and RCPCH, March 2010, http://www.rcpch.ac.uk/sites/default/files/Fever%20Project%20Report.pdf

[2] *Standards for Children and Young People in Emergency Care Settings* RCPCH 2011 http://www.rcpch.ac.uk/child-health/standards-care/service-configuration/emergency-and-urgent-care/emergency-and-urgent-car

[3] *Guidance for commissioning integrated urgent and emergency care – A 'whole system approach'* RCGP 2011 http://commissioning.rcgp.org.uk/2011/08/guidance-for-commissioning-integrated-urgent-and-emergency-care-a-whole-system-approach/

In 2009/10 4.3m patients aged 0-15 years attended EDs in the UK; attendances are increasing year on year. During normal working hours, 67% of parents prefer to access their own General Practice surgery as first port of call[1] and NHS Direct/24 is the second preferred choice. High numbers of children are seen daily as urgent appointments in general practice. There is a high degree of variability of quality U&EC provision, in particular out-of-hours services.[4].

Help is also sought from urgent care, walk-in or minor injury centres or community-based practitioners depending on local provision and awareness. Parents explain their choice to visit ED as either being due to uncertainty about GP access at the time the parent most wants, or concerns that the illness is severe and requires hospital assessment.

Children under 4 years of age have on average 6 consultations per year with their GP practice, and often these are urgent appointments. Despite increasing numbers of ED attendances and hospital admissions, general practice occupies a central position in the health of ChYP[5], and there is also a move from care in hospital to managing ChYP through ambulatory care, NHS111 (England), extended GP service provision and community children's nursing teams.

Differences between U&EC for adults and children

Service planning and commissioning arrangements for ChYP should acknowledge the following differences compared with adult U&EC :

- The frequency of emergency consultations (GP and ED) and emergency hospital admissions is relatively high in the 0-4 age group compared with 5-65 year old people (65+ is also high)
- When parents seek help for acute illness or injury in their children, there is a greater urgency to their need compared with seeking help for their own illness or that of an adult; this is determined by both worry, and convenience (trying to balance the needs of the whole family)
- Calls to the ambulance service are unusual (3% of cases in fever study[1], and very sick children are more likely to be brought directly to the ED by parents, without warning
- children aged 0-2 years in particular form a vulnerable group, in terms of difficulty of diagnosis and the propensity to decompensate quickly

[4] *General Practice Out of Hours Services: Project to consider and assess current arrangements* Dr David Colin-Thomé and Professor Steve Field. Jan 2010 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111893.pdf

[5] *RCGP child health strategy 2010-15:* RCGP November 2010 http://www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf.

- failure to recognise the severity of illness was one of the key avoidable factors in the pilot study for the Child Death Review[6]. Many healthcare professionals are less confident and competent diagnosing children. Without safe provision of skills, clinical errors and over-referral to other services become a problem.
- "zero length of stay" (<24 hours) admissions are frequently cited as evidence of inefficient healthcare or avoidable hospital admission, but common in ChYP. When professionals' views are sought, it is clear that this is a clinical necessity and not due to clinicians being risk averse; children have frequent minor illnesses, are hard to diagnose, but can become unwell very quickly. Due to the low incidence of serious illness in the UK, the outcome for the vast majority is discharge following a period of observation (usually up to 12 hours)
- an inappropriately high number of referrals from one healthcare provider to another occur in young children, presumably due to lack of confidence in the staff concerned
- telephone triage of children is difficult: symptoms are vague and face-to-face examination is often recommended by NHS Direct/24 and GP surgeries
- the clinical expertise for this patient group can fall between two specialties: emergency medicine and paediatrics; if in a locality there is no paediatric emergency medicine consultant, then both emergency medicine and paediatric consultants should be involved where clinical advice is needed

High quality U&EC for ChYP

Clinical Standards

Clinical care for specific conditions is increasingly defined by organizations, for example, the National Institute for Health and Clinical Excellence, Scottish Intercollegiate Guidelines Network, RCPCH, RCN and CEM. Most common conditions such as fever, urinary tract infection, head injury, meningococcal disease, and diarrhoea and vomiting in children under 5 have clear evidence-based national guidelines endorsed by these organizations and all U&EC services should, as a minimum, comply with these where available.

Staffing, Competencies and training

There are clear standards for numbers, training and skills for staff working with ChYP in U&EC set out in the "Red Book"[7] A variety of reports have commented on the need for better acute paediatric skills and services[8][9][10][11] and it is important that service planners and commissioners are assured that the competencies and

[6] *Why Children Die: A Pilot Study* CEMACH 2006 www.injuryobservatory.net/documents/why_children_die1.pdf

[7] Standards for Children and young people in Emergency Care Settings, RCPCH 2011 (in press) http://www.rcpch.ac.uk/child-health/standards-care/service-configuration/emergency-and-urgent-care/emergency-and-urgent-car

skills of the workforce are sufficient for the complexity and pattern of service need.

In general, U&EC staff who do not work with ChYP full-time feel under-confident with this age group, for reasons such as fear of making mistakes or lack of training. The Department of Health and royal colleges have supported educational material such as the e-learning portal "spotting the sick child" www.spottingthesickchild.com.

Service design and governance

Service planning and commissioning arrangements around the United Kingdom should work to reduce variations in the provision of services that support the U&EC pathway for ChYP. Service provision must be co-ordinated, responsive, safe and effective. If U&EC services are reconfigured or reprovided, the care of ChYP must be specifically scrutinized and recommendations set out in "The Way Ahead" taken into consideration[12]. This is best achieved by co-ordinating a local response, on the basis of advice from an Emergency Department consultant (ideally with paediatric sub-specialty training), a lead paediatrician from the network's main hospital, and a primary care /service planner/commissioning lead for U&EC.

All services of initial point of contact should ensure that their risk assessment and clinical decision making tools are correct for ChYP and neither miss serious symptoms and signs, nor have a threshold which is risk averse, requiring one or more further points of healthcare contact. A recognized clinical decision support system such as NHS Pathways should be used for all telephone or e-contacts. NHS Direct/24 are popular with parents. New services such as NHS 111 (England) need to ensure development of the right assessment and management tools for ChYP, with correct usage of local facilities.

Models of care (and the costs of care) vary throughout the United Kingdom, to cater for local population needs. Families prefer care closer to home, but clinical standards of care must not be compromised by a dilution effect when facilities and expertise are spread amongst multiplicity of services. U&EC for ChYP is often high volume, low complexity and low cost, but provision of clinical care cannot

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[8] *Health care service standards in caring for neonates, children and young people* RCN 2011 http://www.rcn.org.uk/__data/assets/pdf_file/0010/378091/003823.pdf

[9] *Facing the Future: Standards for Paediatric Services*, RCPCH, Dec 2010 http://www.rcpch.ac.uk/facingthefuture

[10] *Not just a matter of time: a review of urgent & emergency services in England*, Healthcare Commission, September 2008 http://www.cqc.org.uk/publications.cfm?fde_id=10575

[11] *Children and Young People Emergency and Urgent Care Pathway*, NHS Institute for Innovation and Improvement, 2008 http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on%3A_emergency_and_urgent_care_pathway.html

[12] The Way Ahead College of Emergency Medicine 2008

easily be moved between different sectors without risking quality of care. Clinical engagement in reconfiguration or reprovision arrangements, is paramount. Tariffs or other financial arrangements must not be used perversely, compromising clinical care.

Service evaluation should seek not only to examine local practice, but also to benchmark against national guidelines and against quality measures in other, similar standards. It is important that service planning, commissioning and provision of Out-of-hours GP services for ChYP incorporates clear, robust clinical governance arrangements including trend analysis of clinical performance for common and/or high impact conditions to help raise and maintain standards[13] The Urgent and Emergency Care Clinical Audit Toolkit is recommended for this[14] together with the wider work of the NHS Institute for Innovation and Improvement[15]

In the near future it is anticipated that there will be an increase in localities where the main ED is replaced by an urgent care facility, or the in-patient paediatric unit is replaced by a Short Stay Paediatric Assessment Unit (SSPAU)[16] or indeed closed. Where this occurs, clinicians and service planners must work closely together to ensure safe provision of care. Advice on such matters is also available from both the College of Emergency Medicine and the Royal College of Paediatrics & Child Health.

Clinical quality indicators for EDs were introduced in England in April 2011[17] and replace the less sophisticated 4-hour target for arrival and discharge; they apply equally to ChYP as they do to adults. They include standards for safer discharge of children from the ED with close senior doctor involvement. Each service or department's new Clinical Quality Indicators for U&EC (England) are publicly available. The focus on quality outcome measures means that all health care providers must ensure that they deliver services to an agreed standard. In Scotland an emergency care framework for ChYP was published in 2006.[18] and in Northern Ireland

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[13] General Practice Out of Hours Services: Project to consider and assess current arrangements Dr David Colin-Thomé and Professor Steve Field.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111893.pdf

[14] Urgent and Emergency Care Clinical Audit Toolkit (RCGP, RCPCH, CEM 2011)
http://www.rcgp.org.uk/PDF/Urgent_Emergency_Care_Toolkit_30_March_2011.pdf

[15] Focus On Emergency and Urgent care Pathway for Children (NHS Institute for Improvement and Innovation)
http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on:_emergency_and_urgent_care_pathway.html

[16] Short Stay Paediatric Assessment Units Advice for commissioners and providers RCPCH 2008
http://www.rcpch.ac.uk/sites/default/files/asset_library/Publications/S/SSPAUK.pdf

[17] DH: A+E Clinical quality Indicators: Data Definitions.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122892.pdf

[18] Emergency care framework for children and young people in Scotland
http://www.scotland.gov.uk/Publications/2006/09/19153348/8

Communication between U&EC providers

It is crucial that departmental computer systems and patient information systems are aligned and communicate effectively with each other to reduce risk across patient journey. Lack of clinical information in U&EC consultations is notoriously common and inevitably leads to over-admission to hospital. U&EC documentation often occurs on stand-alone systems, and information-seeking (to reduce risk) is difficult in the time frame of the consultation and the fact that many consultations occur out-of-hours.

Poor information sharing, particularly within smaller settings such as Walk-in centres or Minor Injury Units which may be provided by the independent sector, is a risk which must be balanced against data protection issues. However lack of information is frequently cited as a cause of over-referral to secondary care (from these centres, and from EDs). It is important for staff to be able see information about frequent use of U&EC services, as this is often a sign of significant social and child protection issues and difficulty in collating information has repeatedly been implicated in child protection serious case reviews, and national reviews of safeguarding. Often the GP is the only healthcare professional able to have an overview of U&EC usage, but this depends upon notification to the GP being written into contracts for non hospital settings such as walk in centres .

Child protection and safeguarding

All staff (including those in adult-based settings) should be trained in how to recognise and act on suspected child abuse or neglect, and to consider sharing information where high risk adult patients are known to have children who are being exposed to risk. All settings and staff within them must be compliant with statutory guidance relating to child protection including links with LSCBs and intercollegiate guidance[19][20] and this should be mandated on all service specifications and contracts. Specifically there must be easy secure access, both in and out-of-hours to local authority child protection status information either electronically or through robust, swift and regularly audited processes within which staff work confidently and effectively to assess all children for risk irrespective as to whether they are already recorded with concerns.

Unscheduled attendance at U&ECs are an area of high child protection risk and sound, swift communications links with primary care, often through the appointment of a liaison health visitor are crucial.

[19] "Working Together to Safeguard Children" HM Government, England, 2010 (revision pending) https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010

[20] Safeguarding children and young people - roles and competencies for healthcare staff http://www.rcpch.ac.uk/sites/default/files/Safeguarding%20Children%20and%20Young%20people%202010%20final_v2.pdf

Public and Patient Involvement

The following quote symbolizes parents' feelings when a child is acutely ill, and is borne out by other research in this field:

> *"Just for reassurance really and just to make sure that, you know, somebody else's opinion. Because you know what it's like when you've got kids you feel guilty for taking them to the doctors and guilty for not, so as it was the evening I thought I'd ring the NHS Direct and see what advice they had."*
> (Parent of 3-year-old, 2 contacts, out of hours). DH fever audit[1]

There is a fear of unnecessarily "bothering" NHS services and being criticized for doing so, which is balanced by the fear of not acting promptly enough for serious illness or injury. It is important that services recognise these conflicts and are designed to accommodate these social factors alongside the clinical issues above.

A fundamental tenet of service improvement is the involvement of patients themselves, as stressed by Professor Sir Ian Kennedy's report "Getting it right for children and young people"[21], and the government's white paper for England "Achieving equity and excellence for children"[22] All relevant stakeholders must ensure that the child or young person's needs are paramount, which may challenge traditional professional boundaries and accountabilities[23] and require development of meaningful service standards for a collaborative, pathway-based configuration.

The contributing Colleges (to this document) are jointly developing a Patient Reported Experience Measure (PREM) survey suitable for use for children, by all U&EC providers. Template surveys have been designed with involvement of ChYP and their parents, and can be answered by the ChYP themselves. Contributing to the Clinical Quality Indicator dashboard requirement for patient feedback, the template surveys should be complemented by more detailed survey, analysis and feedback systems to respond to users' views at a local level. [24] The template survey will be available at the end of 2011.

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[21] *Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs*, DH England 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119446.pdf

[22] *Achieving equity and excellence for children* DH England September 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

[23] RCN standards dochttp://www.rcn.org.uk/__data/assets/pdf_file/0010/378091/003823.pdf

[24] Patient Reported Experience Measure - Emergency care http://www.rcpch.ac.uk/child-health/research-projects/prem/patient-reported-experience-measure-prem-urgent-and-emergency-ca

Environment

NHS Health Building Notes and criteria for building design of facilities accommodating U&EC care services for ChYP are available and should be complied with[25]. This includes as far as possible separate facilities for children and for adolescents, and issues such as toys/games/books/magazines and security considerations. The employment of a play specialist in larger organisations has a positive effect on preparing and comforting children for assessment and clinical procedures.

Written information and advice for young people parents and carers about local urgent care services and managing their conditions should be available, and units should be encouraged to comply with the "You're Welcome" criteria for accessibility and attitude to young people using services[26] .

Diversion and discharge

Hospital admission avoidance goes hand in hand with safe discharge. When dealing with an undifferentiated urgent and emergency case mix good safety net processes include the ability to observe children for a short period. There will be some children for whom a short stay assessment, when there is diagnostic uncertainty, is required supported by basic investigations. These children might be better served being looked after in a Short Stay Paediatric Assessment Unit[27] adjacent to the ED or paediatric ward[28] or in a nearby hospital, rather than an inpatient bed, or indeed may be cared for at home with support from an acute skills based Community Children's Nursing service[29]

Conclusion

Current U&EC pathways have not always served ChYP particularly well: multiple healthcare contacts are common, and clinical assessment skills are less robust than for adults. The public can be confused as to how, when and where to access services when their children become suddenly unwell. Recent contractual and legislative changes have failed to develop a system that has agreed competencies and standardised, evidence-based protocols for the professionals that provide U&EC. The settings in which children are seen vary considerably and we lack an integrated IT policy and standardised transport approach. We must ensure that policy makers, professionals and providers of U&EC work

[25] Space for Health contains building notes and design criteria for healthcare settings in the UK. Specific to A&E in England is HBN 23, and for children's settings HBN 22. Access to these documents for free is restricted to NHS or government staff. www.spaceforhealth.nhs.uk

[26] *"You're Welcome"* Quality criteria for young people-friendly health services DH England 2011 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126813

[27] SSPAUs guidance http://www.rcpch.ac.uk/sites/default/files/asset_library/Policy%20and%20Standards/SSPAU.pdf

[28] Facing the Future – Modelling paediatric services April 2011

[29] NHS at home: children's community nursing services DH (2011) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124898

collaboratively and audit their services against agreed quality outcome measures to ensure that ChYP receive the best possible care.

Service development must take clinicians' views into account, especially those of both paediatrics and emergency medicine, and service evaluation for effectiveness and safety should comprise whole patient journey evaluation rather than each individual healthcare contact.

Recommendations:

- Clear needs assessment and modeling of urgent and emergency care access and provision specifically for children's services that reflects demand and casemix (illness vs injury, severe vs minor presentations)
- Safe provision of U&EC services for this age group is essential and requires separate consideration from provision for adults
- Contracted staffing levels and competencies for children trained clinicians must reflect the standards set by RCPCH, RCN and CEM
- Audit and Quality Assurance steps to ensure that all U&EC providers are adhering to national guidelines on common conditions and have robust child safeguarding procedures
- Information transfer arrangements and access to records across providers is fundamental to an integrated service and must be specified by service planners and commissioners
- Whole pathway commissioning for children's services that includes ED attendance or hospital admission avoidance by easy availability of GP urgent appointments and consultant led provision of rapid access paediatric clinics
- Alternatives to full hospital admission by provision of Short Stay Paediatric Assessment Units (with the same role as Clinical Decision Units for adults) run in partnership with Emergency Departments, as well as early discharge enablement by community nursing and SSPAUs
- Children's needs to be respected in new build or refurbished premises so there are protected screened areas and access to toys and games
- A passion for participation of ChYP and clear evidence of how their views and experiences affect provision.
- Ongoing audit, benchmarking and analysis to ensure services are cost effective with monitored and shared outcome improvement objectives, and quality of care maintained during changes to local services.