# Quality Schedule of Standards for Children's Surgery And Anaesthesia - 2016

**Including, but not limited to, ophthalmology, orthopaedics, ENT, OMFS, urology, general paediatric surgery**

**Principles:**

- Trusts should comply with overarching published guidance and standards relating to the provision of care for children and young people, including, but not limited to, Royal College of Nursing and Royal College of Paediatrics and Child Health.
- All Trusts should be clear in their role in the provision of children's surgery and there should be clear lines of accountability and governance.
- Care and treatment should be child centred, focused on the needs of the child not the service; at all times the best interests of the child are paramount.
- Children undergoing surgery or procedures requiring general anaesthesia should be cared for by multidisciplinary staff trained and experienced in the care of children in an environment that is suitable for children. There should be no occasional practice.
- Children, young people and parents should have up to date and accurate information and where possible participate in their care.

**The quality schedule:**

- This document identifies requirements for the provision of children's surgery, built upon the foundation of the Children's Surgical Forum Standards for Children's Surgery, 2013. Mapping against these standards has been included where applicable. They apply to services provided in a DGH and in specialist surgical services in tertiary hospitals. It is noted there may be specific sub-specialty guidelines, for example Dental Extractions under General Anaesthesia, which should be adhered to where applicable.
- Y&H Variation provides additional guidance and clarification to Providers and Commissioners.
- **Core** standards are identified; these ensure a safe and high quality service for children requiring surgery**.**
- **Developmental standards**; it is expected that these will be developed further over time and therefore will need regular review.
- This quality schedule has been produced by the Yorkshire and Humber Children's Surgery and Anaesthesia Task and Finish Group, hosted by the Children's Strategic Clinical Network.

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## Quality Schedule

| No. | Standard | Y&H Variation | Measure | Core/ Develop | CSF 2013 No. |
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| **Network Arrangements** | | | | | |
| 1.1 | There is an identified network lead/director | There must be a recognised, resourced, network clinical lead with authority and accountability | ▸ Role identified in job plan.<br>▸ Reviewed at appraisal. | D | 6.1 |
| 1.2 | The network is supported by contractual agreements that specify service requirements and outcomes and is appropriately resourced on an administrative and financial basis. | | ▸ Copies of contracts.<br>▸ Appropriate audit and review. | D | 6.2 |
| 1.3 | Clinician succession is planned to ensure the future sustainability and integrity of the network. | | ▸ Workforce mapped on an annual basis. | D | 6.3 |
| 1.4 | There is multidirectional flow of services within the network. | | ▸ Description of services. | D | 6.4 |
| 1.5 | Agreed guidelines and protocols for managing the service are in place covering the full patient pathway<br><br>**Best Practice:**<br>There is a forum for sharing best practice and development of the service including all contributors.<br><br>Methods of communicating with all those delivering children's surgical services within the unit/network are established. | | ▸ Protocols and guidelines in place.<br>▸ Regular assessment of performance in place.<br>▸ Evidence of working to national institute for health and Clinical excellence (NICE), Scottish intercollegiate guidelines network (SIGN), or other national guidelines where available | D | 6.5 |
| 1.6 | There is regular (at least annual) network review of patient outcomes and experience. | | ▸ Evidence of review.<br>▸ Measures to improve service delivery are in place. | D | 6.6 |

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| 1.7 | Processes are in place to identify and monitor network risks and critical incidents. | | ▸ Evidence of written processes.<br>▸ Examples of responses to effect change. | D | 6.7 |
| 1.8 | Defined arrangements and standards for the transfer of children are in place and adhered to and regularly audited. | | ▸ Regular (not less than annual) audit by networks with involvement of relevant surgical teams. | D | 6.8 |
| 1.9 | Children's surgical services delivered via a network have arrangements in place for image transfer and telemedicine and agreed protocols for ambulance bypass/transfer.<br><br>**Best practice**<br>Planning ensures adequate beds are available across the network to reduce delays for children being transferred. | | ▸ Arrangements agreed.<br>▸ Written policy on transfer/ bypass, audited regularly. | D | 6.9 |
| 1.10 | Network undertakes arrangements for peer review | | ▸ Evidence of peer review | D | |
| **Trust Governance and Leadership** | | | | | |
| 2.1 | There is a designated children's lead at trust board level. | | ▸Role identified in job plan<br>▸Reviewed at appraisal | C | 7.1 |
| 2.2 | There is commitment from the executive team and senior staff to the provision of a high quality children's surgical service. | | ▸Demonstrated in the organisation's published plans, reports and the presence of a management structure to support the service | D | 7.2 |
| 2.3 | There is a defined governance structure to assure the quality of the service and allow for continuous improvement. | | ▸Governance structure and regular discussion at Board level | D | 7.3 |
| 2.4 | The children's surgical service has an identified children's nurse lead. | | ▸Role identified in job plan<br>▸Reviewed at appraisal | C | 7.4 |

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| | **Best Practice:**<br>Throughout the care pathway, children are looked after by registered children's nurses. | | | D | |
| 2.5 | There is a designated lead responsible for managing quality assurance data regarding the performance of the network. All networks collect data to capture information on relevant annual surgical and anaesthetic activity. | | ▸Role identified in job plan<br>▸Reviewed at appraisal | C | 7.5 |
| 2.6 | Leads have provision within their job plan to champion and develop children's surgical service provision within the organisation | | ▸Role identified in job plan<br>▸Reviewed at appraisal | D | 7.6 |
| 2.7 | All who come into contact with children and parents have complied with the NHS employment checks, including *DBS – Disclosing and Barring Service)*.<br><br>**Best Practice:**<br>Where clinicians work in multiple centres, agreements are in place to provide assurance to all parties that NHS employment checks have been carried out by the main employer. | | ▸Evidence of HR Checks<br><br>▸Use of Certificate of Fitness for Honorary Practice | C<br><br>D | 7.7 |
| 2.8 | Arrangements are in place to safeguard and promote the welfare of children and young people, and to cooperate with other agencies to protect individual children and young people from harm.<br><br>**Best Practice:**<br>Staff are provided with sufficient time and opportunity to ensure they are able to meet this requirement. | | ▸Copies of policy/arrangements<br><br>▸Example job plans/ arrangements demonstrating opportunities are provided. | C<br><br>D | 7.8 |
| 2.9 | All staff who come into contact with children and young people are trained in safeguarding to the appropriate level as defined in the intercollegiate framework *Safeguarding Children and* | All anaesthetists and surgeons who work with children have training in safeguarding [to level 2 as a minimum] and are aware of the arrangements for child protection in their own | ▸Evidence that this is documented in the appraisal process<br>▸Copies of valid Mandatory | C | 7.9 |

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| | *Young people: roles and competences for health care staff*. | hospital | and Statutory Training (MAST) certificates | | |
| 2.10 | The service submits data to prescribed national audits. | Providers to take part in audit activity as recommended by the network. | ▸ Participation monitored via quality accounts.<br>▸ Outcomes monitored through governance systems.<br>▸ If appropriate, outcomes are monitored via the commissioning board. | C | 7.10 |
| 2.11 | There is a programme of audit across all elements of the service. | Children's Surgery and anaesthesia is included routinely in multi-disciplinary departmental audit. Which should incorporate:<br><br>a) Method to regularly analyse/review major complications, including deaths following discharge from hospital<br>b) Outcomes<br>c) Critical and untoward incidents<br>d) reviews of perioperative deaths | ▸Statement of compliance/copy of Terms of Reference and meeting records<br>▸Evidence of audit<br>▸Outcomes monitored through governance systems | C | 7.11 |
| 2.12 | There is a regular (at least annual), multidisciplinary review of patient outcomes involving all relevant specialties.<br><br>Regular M&M/MDT reviews of individual cases take place to identify areas of good practice and areas for improvement.<br><br>Processes for identifying critical incidents and monitoring action plans are in place, for example, engagement with clinical quality review processes of commissioners.<br><br>**Best Practice:** | Separate audits are undertaken for elective and emergency procedures | ▸ Notes of and actions from morbidity and mortality (M&M)/multidisciplinary team (MDT) meetings specifically relating to children.<br>▸ Data is benchmarked against national outcomes where available<br>▸Board scrutiny of serious untoward incidents, summary hospital-level mortality indicator (SHMI) data and other outcome-based information. | C | 7.12 |

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| | There is regular and systematic capture of patient and carer reported outcomes, including those admitted for unscheduled care.<br><br>Risk and clinical governance groups review the outcomes of children's surgery.<br><br>SHMI data are reviewed within organisations for unscheduled surgical care at specialty level. | | ▸Evidence of Trust engagement with quality review processes of commissioning organisations | | |
| 2.13 | There is a policy in place and an identified lead for the transitional care of young people moving to adult services, including children and young people with special needs | | ▸Policy in place<br>▸Role identified in job plan and reviewed at appraisal | D | 7.13 |
| 2.14 | Structured arrangements are in place for the handover of children at each change of responsible consultant/medical team. Adequate time for handover is built into job plans.<br><br>**Best Practice:**<br>Electronic transfer of care documents to assist with verbal handover arrangements. | | ▸Handover processes and documentation | C<br><br>D | 7.14 |
| 2.15 | The WHO *Surgical Safety Checklist*18 (or a local variant thereof) is used for all appropriate procedures | | ▸Local arrangements and audit | C | 7.15 |
| 2.16 | There is a written policy regarding the age range of children anaesthetised and operated upon within the hospital (and for the out- of-hours period if the level of paediatric anaesthetic competences is different). | Every hospital trust that receives children must have a policy for securing both emergency and non-urgent surgical services for children, including surgical sub-specialties. This should specify/identify:<br><br>(ii) the age ranges of children for whom the Trust provides emergency and elective surgery<br>(iii) the age ranges of children for whom the Trust provides anaesthesia | ▸Copies of policy documents<br>▸Written policy with annual review<br>▸Effectiveness of policy is evaluated with audit of outcomes, including transfers and untoward incidents | C | 7.16 |

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| 2.17 | Pain management policies are in place and followed. A pre and postoperative pain assessment takes place for every child. All nurses and support workers delivering care to children and young people are competent in this. The service is supervised by a paediatric anaesthetist. | | ▸Provider statement of compliance<br>▸Policy document<br>▸Regular audit | C | 7.17 |
| 2.18 | Every hospital trust that receives children must have a policy for securing both emergency and non-urgent surgical services for children, including surgical sub-specialties*. This should specify/identify:<br><br>i. the responsibility for the clinical management of children presenting in an emergency<br><br>iv. the circumstances when there should be stabilisation and transfer to a Trust providing [more] specialised children's surgery/anaesthesia | | ▸ Copies of policy documents<br>▸ Written policy with annual review<br>▸ Effectiveness of policy is evaluated with audit of outcomes, including transfers and untoward incidents | C | |
| 2.19 | There should be specific guidance supporting the appraisal process to ensure that all clinicians treating children have responsibility to define this component of their practice; demonstrating commitment to achieving good outcomes, and maintaining competency. | | ▸Written guidance to appraisers and appraises<br>▸Regular network feedback from clinicians regarding effectiveness of the appraisal process | D | |
| 2.20 | Pharmacy staff with specialised paediatric knowledge available to provide advice and ensure safe and effective management of drugs in children.** | | ▸ Provider statement of compliance | C | |
| 2.21 | All Trusts follow standard protocols for surgical emergencies including: †† and ◊<br>a) Airway obstruction | | ▸ Copy of written policy | C | |

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| | b) Shock<br>c) Head injury requiring intubation<br>d) Isolated head injury (not req. neurosurgery)<br>e) Isolated head injury requiring neurosurgery<br>f) Head injury with other serious injuries<br>g) Suspected ventriculoperitoneal shunt malfunction<br>h) Acute scrotum<br>i) Severe burns | | | | |
| 2.22 | Emergency surgery for children only take place in hospitals:<br>a) that have children's inpatient facilities††<br>b) that have access to paediatric high dependency care capability**<br>c) that have arrangements for providing emergency treatment, initiating intensive care and stabilising the critically ill child prior to their transfer for PIC | | ▸ Trust statement of compliance | C | |
| **Education and Training** | | | | | |
| 3.1 | Mechanisms are in place to assess staff competency and identify training needs. | Surgeons and Anaesthetists designated to provide elective surgery in children care for a sufficient number of children annually to maintain a high level of competence. | ▸Records of annual appraisal and personal development plans, to include paediatric activity review and outcome based evidence | C | 8.1 |
| 3.2 | Provision is made in job plans for all staff to participate in training and CPD activities. Networks support, develop and provide CPD. Medical royal colleges set standards for CPD in their respective specialties and provide guidance and tools to support doctors in planning and managing their CPD activities. | **Anaesthetic Support Staff**<br>When a child undergoes anaesthesia the anaesthetist is assisted by staff who have competence and skills in paediatric airway support:<br>a) invasive and non-invasive ventilation<br>b) extubation<br>c) recovery<br>d) resuscitation<br>e) Level 1 safeguarding children<br>*all of the above must be met*<br><br>**Surgeons and Anaesthetists** | ▸Evidence that this is documented in the appraisal process<br>▸Example job plans with supporting professional activity (SPA) time allocated<br>▸Description of CPD activities provided | C | 8.2 |

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| | | All surgeons and anaesthetists providing care to children undertake continuing professional development in the care of children (including communication skills) | | | |
| 3.3 | Staff are provided with opportunities to fulfil training and CPD needs, for example through the use of training courses, secondments or proleptic appointments. | | ▸Example arrangements for secondments | D | 8.3 |
| 3.4 | Consultants work within the limits of their professional competence and, where there are unexpected circumstances requiring that they act beyond their practised competences, support is available from colleagues within the service / network. | | ▸Description of support | C | 8.4 |
| 3.5 | Training in children's surgery is organised according to the requirements of the relevant specialty curriculum. | **Surgeons and Anaesthetists**<br>All surgeons and anaesthetists providing care to children undergo child-specific training, education and assessment as required by the relevant Specialist Advisory Committee | ▸Evidence that this is documented in the appraisal process<br>▸Recorded in annual review of competence progression (ARCP) | C | 8.5 |
| 3.6 | Trainees' supervision is appropriate to their level of competence. | All trainees are supervised by an appropriately experienced consultant appropriate to their level of competence | ▸Trust statement of compliance<br>▸Recorded in annual review of competence progression (ARCP) | C | 8.6 |
| 3.7 | All surgeons and anaesthetists operating on, and anaesthetising, children regularly undertake paediatric life support training. | | ▸Recorded in appraisal | C | 8.7 |
| 3.8 | Anaesthetists with no regular paediatric commitment but who have to provide out- of-hours cover for emergency surgery or stabilisation of children prior to transfer maintain their skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job. | | ▸Recorded in appraisal<br>▸Example job plans | C | 8.8 |

| Children, Young People and Families | | | | | |
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| 4.1 | Children and families are able to access, at all times, a dedicated member of staff with whom they can discuss (or arrange discussion with the relevant clinician) treatment options, diagnostic findings, expected recovery timescales, complications, etc.<br><br>**Best practice:**<br>Patient experience standards for this role are in place. | Consideration to the You're Welcome recommendations should be given | ▸ Role description/rota for this post.<br>▸ Patient-reported experience measures (PREMS) are monitored.<br><br>▸ Patient experience standards in place and audited. | C<br><br>D | 9.1 |
| 4.2 | There is a system of communicating the name of the responsible consultant to patients and families, occurring on admission and at every change of consultant responsibility. | | ▸ Monitored on a ward-by-ward basis. | C | 9.2 |
| 4.3 | Information is provided to patients and supporters at each stage of the care pathway. Communication with patients and supporters is consultant-led. | Before admission for operation/procedure, the child and family are provided with information about the hospital, as well as the pre and postoperative management and discharge arrangements. Where possible, information should be verbal, written and illustrated parent/carers have the opportunity to discuss the information with the clinical team. | ▸ Evidence of existing procedure<br>▸ Presence of written information where applicable.<br>▸ PREMS are monitored. | C | 9.3 |
| 4.4 | Printed patient information leaflets on common children's surgical conditions and anaesthesia are available.<br><br>**Best practice:**<br>Patient information is also available electronically. | | ▸ Presence of information literature. | C<br><br>D | 9.4 |
| 4.5 | The service has arrangements to provide support services such as translation, play therapy and other necessary therapies, social care, interfaith, advocacy advice and support, health visitors and liaison nurses. | | ▸ Provider statement of compliance<br>▸ Description of services offered. | C | 9.5 |

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| 4.6 | The decision to operate includes the provision of information, informed consent and confidentiality.<br><br>Arrangements are in place to ensure that guidance on consent for treatment and sharing information with supporters is followed. | | ▸ Examples of information provided to parents and carers.<br><br>▸ Written policy in place. | C | 9.6 |
| 4.7 | Procedures minimise anxiety for the child (e.g. shortest fasting times, allowing children to wear their clothes to theatre, imaginative modes of transport to and from theatre, taking into account safety and good communication among staff to minimise waiting times). | | ▸ Description of facilities. | D | 9.7 |
| 4.8 | Where appropriate, the child contributes to decisions regarding their care according to their understanding. Patients and carers are kept updated of changes as they occur. | | ▸PREMs are monitored | C | 9.8 |
| 4.9 | The anaesthetic room is child friendly and parents are supported in comforting their children during induction | | ▸Description of facilities | C | 9.9 |
| 4.10 | In the recovery area, there is a physical separation between children and adult patients.<br><br>Parents/carers are able to be present with their child when they wake up. | There should be a separate or screened recovery area from that used by adults.<br><br>Screening should block the line of sight between child and adult patients and preserve the dignity of adult patients in the recovery area when parents/carers are with their child, but must not create risk by isolating the recovery staff and/or patient.<br><br>The parents/ carers are allowed to be with the child as far as is reasonable in the ward, in the anaesthetic induction room and when fetching the child from recovery, and to participate in the care of the child in the ward. | ▸Provider statement of compliance<br>▸Description of facilities | C | 9.10 |

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| 4.11 | As soon as possible post-surgery a member of the medical/nursing team updates the child's family of the outcome of surgery. | | ▸Feedback from children and family. | C | 9.11 |
| 4.12 | Information about patients and their conditions is imparted in a sensitive manner and communicated in such a way as to preserve privacy, dignity and confidentiality. | | ▸ Provision of private facilities for discussion.<br>▸ Feedback from patients/supporters. | C | 9.12 |
| 4.13 | Patients and their families are given clear information on discharge from the service and are able to make contact with a healthcare professional for advice and support following discharge.<br><br>Primary care colleagues receive timely and accurate discharge information in order to support the patient in primary care.<br><br>**Best practice**<br>The service offers a telephone follow-up service for patients and has defined links with general practice. | A discharge plan is in place as a minimum should include a letter to the GP (copied to the patient) and a briefing for the patient and their parent about likely after effects, any follow-on treatment needed, any continuing drug therapy, and the implications for school attendance, together with a contact point where relevant liaison and support from community services | ▸Statement of compliance/copy of policy<br>▸ Standard written information is available<br><br>▸Evidence of telephone advice offered<br>▸Feedback from patients/supporters<br>▸Description of telephone follow-up service and GP links | C<br><br>D | 9.13 |
| | The service has mechanisms to receive feedback from patients and supporters.<br><br>**Best Practice:**<br>The service has a rolling programme of capturing and auditing a sample of patients' experiences of the service and acts upon the results. | | ▸ Patient experience measures are in place.<br>▸ Feedback audited regularly. | C<br><br>C | 9.14 |
| 4.14 | Mechanisms are in place to involve patients and their family in decisions about the organisation of the service. This should include patient/family groups who are part of a network of regional or sub- | | ▸ Evidence of patient involvement in decisions about service development. | D | 9.15 |

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| | regional services. | | | | |
| 4.15 | All Trusts should adhere to the Yorkshire and the Humber Children and Young People's Charter for Surgery and Anaesthesia | | ▸ Patient experience measures are in place.<br>▸Feedback from children and family. | C | |
| 4.16 | Parents and carers are involved in the care process including physical and psychological preparation of the child for surgery. *** | | ▸ Evidence of existing procedure | C | |
| 4.17 | Procedures for preparing the child for admission to hospital are agreed including ward visits and pre-surgical checks. **** | | ▸ Evidence of existing procedure | C | |
| **Generic Delivery and Environment of Care** | | | | | |
| 5.1 | A named consultant paediatrician is available for liaison and immediate advice and cover.<br><br>**Best practice**:<br>The patient has 24/7 access to a consultant paediatrician | A named consultant paediatrician is available for liaison and immediate advice and support in the event of medical complications of surgical work. | ▸ Description of services and rotas<br>▸Provider statement of compliance | C | 10.3 |
| | In the period immediately after anaesthesia the child should be managed in a recovery ward or post-anaesthesia care unit on a one-to-one basis, by designated staff with up-to-date paediatric competencies, particularly resuscitation (PLS as a minimum). A registered children's nurse should be directly involved with the organisation of the service and training in this area. A member of staff with advanced training in life support for children should always be present.** | | ▸ Provider statement of compliance | C | |

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| 5.2 | The service should have access to clinical support services such as radiology, laboratory services, and physiotherapy appropriate for the type of procedures being carried out. | | ▸Provider statement of compliance<br>▸Evidence of services provided on site | C | |
| 5.3 | There are immediately available appropriate facilities to resuscitate and stabilise and a clearly defined policy for access and transfer to a PICU.**** | | ▸ Statement of compliance/copy of policy | C | |
| 5.4 | Day surgery units have a pain control policy that includes advice about pain management at home, and the provision of 'take home' analgesia and advice.† | | ▸ Copy of written policy | C | |
| 5.5 | All hospitals admitting children should be able to deliver Level 1 CC in a defined appropriate area, classified as a Level 1 PCCU.~ | | ▸ Trust statement of compliance | C | |
| **Elective Care** | | | | | |
| 6.1 | As far as possible, adults and children are segregated in all service areas. Where this is not possible arrangements are made that recognise the needs of children and their carers. | | ▸Provider statement of compliance | C | 10.1 |
| 6.2 | Elective surgery for children is scheduled on dedicated children's theatre lists. Where this is not possible, cases are scheduled with consideration for the needs of children and carers. | There should be separate operating lists for children *or* children needing elective surgery should be grouped together on operating lists and the timing of surgery organised to minimise the distress to the child | ▸ Example lists<br>▸ Evidence of measures in place working towards separate lists where volume is sufficient<br>▸ PREMS are monitored | C | 10.2 |
| 6.3 | In exceptional circumstances where a child requires care from specialist surgical nurses or in specialist facilities within an adult setting, there is liaison with a named registered children's nurse | | ▸ Record of named children's nurse | C | 10.4 |

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| 6.4 | When children are admitted to departments other than the children's unit (e.g., emergency department (ED) or x-ray), there is a process of liaison with a named nurse in the children's unit to ensure appropriate advice is available (e.g., on consent issues and pain management). The advice of a play specialist is also sought. | | ▸ Record of named children's nurse and play specialist | C | 10.5 |
| 6.5 | Sufficient staff are trained, and maintain competencies, in life support on any one shift. In clinical areas (e.g. ED, inpatient medical and surgical wards, recovery areas and day-case facilities) this is to advanced levels e.g. Advanced Paediatric Life Support (APLS), European Paediatric Life Support (EPLS) or equivalent. | | ▸Provider statement of compliance<br>▸Example rotas<br>▸Evidence of training | C | 10.6 |
| **Wards** | | | | | |
| 7.1 | Children are not admitted to adult wards | | ▸Provider statement of compliance<br>▸ Regular audit. | C | 10.7 |
| 7.2 | The on-going care of inpatients/postoperative patients is managed by consultant surgeons, with support from consultant paediatricians where necessary, on children's wards staffed by registered children's nurses and senior surgical trainees (or surgical trust doctors with equivalent competencies). | Children should be nursed in the recovery area by nurses who are either trained in paediatric care, or have recognised experience of post-anaesthetic care of children | ▸ Description of service.<br>▸ Audit. | C | 10.8 |
| **Out Patients** | | | | | |
| 8.1 | Children are seen in designated children's clinics. Where this is not possible, cases are scheduled with consideration for the needs of children and carers. | There are designated surgical outpatient clinics specifically for children with child friendly amenities meeting 'You're Welcome Quality Criteria'<br><br>Where there are no dedicated outpatients, there should be separation from services for adults (temporal/geographical) | ▸ Examples of clinics.<br>▸ Evidence of measures in place working towards designated clinics where volume is sufficient.<br>▸PREMS are monitored. | C<br><br>C | 10.9 |

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| **Emergency** | | | | | |
| 9.1 | The critically ill child with an immediate life-threatening condition is assessed by a senior clinician and the decision to operate or transfer is made promptly, according to network arrangements.<br><br>**Best Practice:**<br>Consultant-led multidisciplinary team resuscitation, assessment and decision of definitive management. | | ▸ Audit of outcomes, untoward incidents and transfers | C<br><br>C | 10.10 |
| 9.2 | For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. | This standard should not over-ride the guidance from NCEPOD reports, advising that out-of-hours surgery/anaesthesia should not be carried out unless the clinical urgency indicates that the risk of delaying the procedure outweighs the benefit. | ▸ Audit of time intervals between admission, decision to operate and operation. | C | 10.11 |
| 9.3 | At any time, the ED rota includes sufficient cover for emergencies in children. | | ▸ Example rotas | C | 10.12 |
| 9.4 | Children have access to a child-friendly environment in EDs. | | ▸ Description of facilities | C | 10.13 |
| 9.5 | Emergency surgery is normally undertaken in hospitals with comprehensive paediatric facilities, 24/7 paediatric cover, children's nursing support and paediatric-competent anaesthetic support.<br><br>**Best Practice:**<br>There is always at least one member of emergency staff on site who is trained and competent in APLS/EPLS or equivalent. | | ▸ Description of service<br>▸ Audit | C<br><br>C | 10.14 |
| 9.6 | Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred | Arrangements are in place to ensure continuous cover by staff with the necessary competence and experience in paediatric surgery and anaesthetics | ▸ Evidence of child-specific training and CPD<br><br>▸Trusts to assess competence | C | 10.15 |

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| | or who cannot wait until a designated surgeon or anaesthetist is available. | | to carry out surgery/anaesthesia in children of specific age groups | | |
| 9.7 | When transfer is required, this is supervised by senior medical and nursing staff. Timely decisions are made and implemented regarding transfer and escort methods. | Agreed protocols for transfer to these facilities are in place with network arrangements and policies to ensure prompt and appropriate transfer to the tertiary centre following stabilisation where necessary. | ▸ Transfer policy or protocol.<br>▸ Audit of transfers including duration and outcome. | C | 10.16 |
| 9.8 | The trust/network has a policy to support surgeons and anaesthetists undertaking life-saving interventions in children who cannot be transferred or who cannot wait until a designated surgeon is available. | | ▸ Written policy in place.<br>▸ Notify such cases to the trust for audit purposes | C | 10.17 |
| 9.9 | All hospitals admitting emergencies have the required resources and equipment to stabilise and resuscitate a child including infants at all times.<br><br>**Best Practice:**<br>Board member for children takes responsibility in conjunction with ED and consultants in paediatrics and anaesthesia. | A full range of paediatric equipment is available in theatres, recovery areas and all other areas where children are anaesthetised as specified in the RCA standards | ▸ Adequacy of resources assessed annually<br>▸ Provider statement of compliance | C<br><br>C | 10.18 |
| 9.10 | Emergency theatres and recovery are staffed by a paediatric-competent theatre team<br><br>**Best Practice:**<br>All theatre staff have child-specific training. | | ▸Evidence in appraisals | C<br><br>D | 10.19 |
| 9.11 | Access to children's critical care facilities is available at all times. Agreed protocols for transfer to these facilities are in place.<br><br>**Best Practice:**<br>Fully staffed high dependency unit (HDU) beds available 24/7 on site.<br><br>Formal arrangement with regional paediatric | | ▸ Included in written policies (link to RCS 10.16)<br>▸ Evidence that contact details are easily available | C<br><br>D | 10.20 |

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| | intensive care unit (PICU) for acceptance and transfer of critically ill children, including retrieval. | | | | |
| 9.12 | Where children present to an ambulatory/day- case facility, there is a robust procedure in place for assessment and transfer if required.<br><br>**Best Practice:**<br>Children have access to a senior paediatrician, a surgeon and anaesthetist.<br><br>Written protocol for assessment and transfer of emergency surgical children. | When transfer is required, this is supervised by senior medical and nursing staff. Timely decisions are made and implemented regarding transfer and escort methods.<br><br>Agreed protocols for transfer to these facilities are in place | ▸ Transfer policy or protocol.<br>▸ Audit of transfers including duration and outcome | C<br><br>C | 10.21 |
| 9.13 | There is trust/network/health board-wide audit of emergency surgery in children. Emergency children's surgical practice is audited at least annually using routinely collected data. Examples: time between admission/decision to operate and the operation taking place, length of stay, morbidity and mortality. Audit should include children's surgical transfers and untoward incidents including unplanned re-admissions and unplanned admissions to a critical care unit.<br><br>Emergency children's surgery is included in inter-network audit of children's surgery.<br><br>**Best Practice:**<br>There should be common and agreed methods of data collection that are easily comparable between trusts. | Separate audits are undertaken for elective and emergency procedures.<br><br>Children's Surgery and anaesthesia is included routinely in multi-disciplinary departmental audit, which should incorporate:<br>a) Method to regularly analyse/review major complications, including deaths following discharge from hospital<br>b) Outcomes<br>c) Critical and untoward incidents<br>d) reviews of perioperative deaths | ▸ Regular audit, outcomes discussed at board level with evidence of feedback to improve practice. | C<br><br>D | 10.22 |
| **Day Surgery** | | | | | |

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| 10.1 | Children's surgery is provided on a day-case basis wherever practical. | | ▸ Example day case lists<br>▸ Regular audit | C | 10.23 |
| 10.2 | A named consultant surgeon is responsible for the care of the child but can delegate to other grades as appropriate. | | ▸ Named consultant responsible for each case<br>▸ Regular audit | C | 10.24 |
| 10.3 | A paediatric-trained consultant anaesthetist is present for day-case surgery but can delegate to other grades as appropriate. | | ▸ Copies of rotas | C | 10.25 |
| 10.4 | Parents and carers are given clear instructions on follow-up and arrangements in the case of postoperative emergency. | | ▸ Copies of information | C | 10.26 |
| 10.5 | A minimum of two registered children's nurses are present in day surgical areas. | | ▸ Copies of rotas | C | 10.27 |
| 10.6 | The outcomes of day-case activity is audited and reviewed. | Children's surgery and anaesthesia is included routinely in multi-disciplinary departmental audit. Which should incorporate:<br>a) Method to regularly analyse/review major complications, including deaths following discharge from hospital<br>b) Outcomes<br>c) Critical and untoward incidents<br>d) reviews of perioperative deaths | ▸ Regular audit and review.<br>▸Statement of compliance/copy of ToR and meeting records<br>▸Outcomes monitored through governance systems | C | 10.28 |
| 10.7 | Processes are in place to facilitate transfer within the network should complications arise. | | ▸ Description of process | C | 10.29 |
| **Day Case Surgery (Without Inpatient Facilities)** | | | | | |
| 11.1 | Elective surgery and anaesthesia is only delivered by consultant surgeons and anaesthetists experienced in the condition. | | ▸ Example rotas | C | 10.30 |

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| 11.2 | The surgeon and anaesthetist remain in the hospital until arrangements have been made for the discharge (or transfer) of all patients under their care. | | ▸ Monitored on a ward-by-ward basis | C | 10.31 |
| 11.3 | At least one member of the team has current advanced paediatric life support training. All team members have up-to-date basic skills for paediatric resuscitation. | | ▸ Appraisal<br>▸ Evidence of training<br>▸ Examples of rotas | C | 10.32 |
| 11.4 | At least one member of the team with up to date basic skills for paediatric resuscitation is present throughout the period the child is in the unit. | | ▸ Example rotas | C | 10.33 |
| 11.5 | A neighbouring children's service takes formal responsibility for the children being managed in the unit. Every effort is made to ensure this neighbouring unit is geographically close enough to ensure support is practical. | | ▸ Formal agreement in place | D | 10.34 |
| 11.6 | Agreed and robust arrangements are in place for paediatric assistance and transfer if required | Processes are in place to facilitate transfer within the network should complications arise. | ▸ Formal arrangements in place and widely known | C | 10.35 |

## Reference List


***** DOH (2003) **National Service Framework for Children Young People and Maternity Services: Standards for Hospital Services**

****** The Royal College of Anaesthetists (2016) **Guidelines for the Provision of Anaesthetic Services**

******* YH SHA, (2008) **Healthy Ambitions, NHS Next Stage Review**

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**†** DOH (2003) **National Service Framework for Children Young People and Maternity Services Standards for Hospital Services**

†† DOH (2006)**The acutely or critically sick or injured child in the district general hospital, a team response**

◊ PIC (2015)**Quality Standards Care of Critically Ill & Critically Injured Children**

**~** Royal College of Paediatrics and Child Health (2014) **High Dependency Care for Children – Time to Move On**