Supporting Paediatric Reconfiguration

A Framework for Standards

July 2008

Royal College of Paediatrics and Child Health
www.rcpch.ac.uk

C O N T E N T S

1. Introduction

Paediatricians and commissioners face considerable challenges providing safe, high-quality services that meet the needs of children and their families in a sustainable manner. New working hours, medical and technological advances, rising public expectations, and the desire to improve the quality of care, all contribute to the need for change. Changes to the configuration of services may be met with considerable opposition due to uncertainty about what will replace established services, from health professionals, professionals in other services, patients, and the general public. The case for change can be complex, with decisions needing to balance key areas of clinical effectiveness, best practice, patient safety, accessibility, staff retention and recruitment, and sustainability.

Any proposals for service change should be based on unambiguous and objective principles that provide a clear case for change. Unfortunately, there is very little evidence to underpin different service configurations, with most guidance based on consensus or experience. In response to these issues, the RCPCH has made use of existing current standards and policies to develop a coherent framework of essential standards that can be used when planning the reconfiguration of acute services for children. In doing so, the RCPCH has drawn on much work that has already been undertaken in this area, such as the 'Standards for the Care of Critically Ill and Injured Children in the West Midlands' (West Midlands Strategic Commissioning Group, 2004) and the proposals and outcomes from the 'Making it Better' consultation for Greater Manchester on the redesign of children's and maternity services, which were endorsed by the Secretary of State for Health in 2007.

1.1 Project remit

The terms of reference of the project were to develop:

- A set of key essential standards of safety and quality of service that should be applicable to any reconfiguration involving children's health services within the UK.
- A framework for assessing proposals against those standards to help both local communities and outside experts in the reconfiguration decision-making process.
- A summary of the issues and unintended consequences that arise during reconfigurations.

Given the broad potential scope, the project team (appendix 1) decided to focus on standards of care for general acute paediatrics. There has been consideration of the interface with specialist, community and primary care, but detailed standards for these areas are beyond the scope of this report particularly given that these will depend on local circumstances.

It should be noted that the key inter-relationships between different specialist paediatric services have recently also been defined (DH, 2008).

The framework intentionally sets out to define a minimum set of standards which are essential to guarantee safety for patients, rather than incorporating standards that are developmental or aspirational. The approach of the working group has not been to develop new standards, but rather to use existing standards, developed by expert groups in their respective fields. The original guidance is referenced in all instances. Only those elements of the expert published or referenced guidance that were considered essential for a safe clinical service are included. This should not be taken to indicate that the group did not endorse the full guidance in the reports that are referenced, simply that the framework identifies only the essential standards for safety. In very occasional instances, the working group considered that a standard was essential to define safe practice even though it was not taken from referenced guidance.

These standards are intended to be applied independently of different service models and this report does not seek to endorse any particular model of service for acute paediatrics. Models of service have been analysed in detail in the recent report 'Modelling the Future' (RCPCH, 2007). The standards that are identified should apply in all settings, but it is recognised that they may be challenging to achieve in some circumstances, such as for the provision of services in remote or rural areas.

The working group has sought to be broad in its approach, recognising the complex relationships between services providing care for children. Wherever possible, rather than defining distinct professional roles, the framework identifies the competencies and skills required to provide a safe service. These competencies could be provided by a variety of healthcare professionals.

All established and proposed acute paediatric services should meet these standards. For any services currently working below the standards, the framework should be used as a benchmark for what should be achieved.

2. Framework of Standards

The proposed framework is outlined in table 1. The standards are divided into several key groupings:

- **Clinical competence in various settings**.
  This section outlines all the essential competencies required – it does not attempt to define which staff should provide these competencies. By considering each setting separately the framework can be used in various possible configurations. In situations where several services are co-located, the immediately available competencies are still applicable and it should not be assumed that the staff providing inpatient paediatric services can necessarily provide the key competencies for other areas, such as emergency departments sited some way away from the children's inpatient service or not co-located with the children's assessment units. It is essential that wherever children are cared for, staff have sufficient skills and competencies to provide clinically safe care.
- **Key services.**
  Outlines the access required to services that support the care of children.
- **Minimum workload**.
  Defines the minimum number of attendances below which specific arrangements are required to ensure that competencies are appropriately maintained.
- **Environment of care.**
  Outlines the requirements for facilities that are required for the safe and appropriate treatment of children.
- **Protocols.**
  Outlines the essential protocols that should be in place for the safe running of a service.

Evidence or policy to support each standard is found on the right hand side of the table. Where, in exceptional cases, no existing guidance was identified to support the standard but it was felt by the working group to be essential, the standard is cited as consensus.

One of the key findings of the recent report 'Why Children Die: A Pilot Study, 2006' from the Confidential Enquiry into Maternal and Child Health was that the failure by healthcare professionals to recognise serious illness in children was a cause of preventable deaths. The report recommended that "all health care professionals who treat sick children should have appropriate training and supervision such that their key skills and competencies can be demonstrated, standards maintained and performance assured" and that "all healthcare institutions need to ensure that staff are aware and implement national guidelines." This standards framework identifies the minimum standards that all acute paediatric services

should meet and the minimum competencies required of the staff providing the service.
In addition to the standards framework there are other key considerations for a safe service that cannot be so easily defined into specific standards. These are explored in the following sections.

2.1 Interfaces

There are interfaces and interdependencies with other services that will be applicable to all settings. The exact standards and configuration will depend on local circumstances, and therefore, while they are not listed in the framework, they are essential interfaces. The provision of the following, and the relationships and protocols between them, must be considered to ensure that there is appropriate and safe access to services:

- Neonatal services.
- Maternity services for neonatal resuscitation.
- Access to tertiary paediatric services.
- Emergency departments.
- Ambulance services.
- Access to routine services locally (e.g. general paediatric surgery, ENT, orthopaedics, plastic surgery, day-case anaesthetic lists for procedures and investigations etc).
- Child and adolescent mental health services (CAMHS).
- Primary care (including GP, Health Visitor, Out of Hours services, Urgent Care services).
- Community paediatric services.
- Community nursing teams.
- Child protection services.
- Local authority children's services.
- Rehabilitation services.
- Allied Health Professionals.

2.2 Communication

Good communication, both within and between teams, and between professionals and children and their families is vital. It is difficult to define a standard for this area, and therefore it is recommended that good communication should be evident through the approach and culture of the service. Examples of essential communication include effective information management systems, information sharing protocols, age-appropriate information leaflets for children and their families, multi-disciplinary meetings, well developed managed clinical

networks and designated liaison workers – to ensure timely reporting of case attendances to primary care trusts (PCTs).

2.3 Accountability and governance

There needs to be a clear governance structure outlining the responsibility and lines of accountability within any organisation, and also for any clinical network or provision of care that crosses organisational boundaries.

2.4 Nursing Standards

The standards of nurse staffing for acute paediatric services have been defined in the Royal College of Nursing report 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2003). A summary of the relevant standards are included in the framework. The RCPCH supports these standards and recommends that they are implemented in all acute paediatric units as soon as possible.

Table 1: Framework of standards

	Location	Specified standard	Supporting evidence/policy
Clinical competencies	Available within emergency department (regardless of whether co-located with inpatient department).	• Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) available at all times. In addition Paediatric Intermediate Life Support (PILS) available at all times. • Basic airway skills available at all times. • Assessment of the ill child and neonate – recognition of serious illness and injury available at all times. • Initiation of appropriate immediate treatment available at all times. • Stabilisation for transfer available at all times • The provision of appropriate pain management at all times. • Effective communication with children and their families. • Tier 1 CAMHS skills at all times. • Named paediatric and emergency department liaison consultants. • Child protection skills (Level 2 as defined in RCPCH 2006 or equivalent) available at all times. Skills to include recognition of vulnerable children and ability to identify when safeguarding procedures are necessary. • A minimum of one registered children's nurse available at all times children are in the department[1]. • A registered children's lead nurse to develop policy and practice[1].	Services for Children in Emergency Departments (RCPCH, 2007) Trauma: who cares? (NCEPOD, 2007) Emergency Care Framework for children and young people in Scotland (Scottish Executive, 2006) The acutely or critically sick or injured child in the district general hospital (DH, 2006) Safeguarding children and young people: roles and competencies for health care staff, an intercollegiate document (RCPCH, 2006) Victoria Climbié Inquiry (Laming, 2003) Defining staffing levels for children's and young people's services (RCN, 2003)

1. Plans should be in place to deliver these nursing standards as soon as possible. The RCN has set a target date for these standards to be fully implemented by 2015.

Table 1: Framework of standards cont..

	Location	Specified standard	Supporting evidence/policy
Clinical competencies	Available within an inpatient paediatric department (in addition to all the competencies outlined for the emergency department).	• Named paediatric consultant on call available to attend within 30 minutes, serving only one clinical site. • Resident clinician trained to equivalent of paediatric medicine level 2 competence with appropriate paediatric consultant supervision. • A minimum of 2 registered children's nurses at all times regardless of the number and age of children.	Consensus A framework of competencies for basic specialist training in paediatrics (RCPCH, 2004) Defining staffing levels for children's and young people's services (RCN, 2003)
	Available within a children's observation and assessment unit (or equivalent) regardless of whether co-located with inpatient paediatric unit and/or emergency department (in addition to the medical and nursing competencies outlined for emergency departments).	• Paediatric consultant available for advice (for opening hours). • A minimum of two registered children's nurses during opening hours.	Consensus Defining staffing levels for children's and young people's services (RCN, 2003)

Table 1: Framework of standards cont..

	Location	Specified standard	Supporting evidence/policy
Clinical competencies	Available on site at all times where an emergency paediatric service is being provided (these skills can be provided by the appropriate competencies).	Anaesthetic competencies: • Resuscitation and stabilisation of critically ill child and neonate. • Stabilisation of deteriorating child. • High dependency and critical care skills for advanced airway, cardiovascular and respiratory support. • Vascular access skills.	Services for children in Emergency Departments (RCPCH, 2007) The acutely or critically sick or injured child in the district general hospital (DH, 2006) Guidance on the Provision of Paediatric Anaesthetic services (RCoA, 2005)
		Surgical competencies: • Paediatric surgical assessment and diagnosis. • Ability to treat life threatening conditions on site (e.g. abdominal sepsis, exsanguination). • Recognition of neurovascular compromise with fractures. • Agreed protocols for managing: airway obstruction, shock, head injury requiring intubation, suspected ventriculo-peritoneal shunt malfunction, acute scrotum, fracture, severe burns, intussusception. • Access to experienced paediatric surgical opinion, either on site, telemedicine or by phone but with rapid response. • Regional network for advice and transfer of surgical and trauma patients.	Services for children in Emergency Departments (RCPCH, 2007) Surgery for Children: Delivering a First Class Service (Children's Surgical Forum, 2007) The acutely or critically sick or injured child in the district general hospital (DH, 2006)

Table 1: Framework of standards cont..

	Support service	Specified standard	Supporting evidence/policy
Services which may be available on site but, if not, must be accessible either through on-call or network provision.	Radiology and laboratory services (including pathology).	• Access to all appropriate investigations. • Access to CT scan and reporting within one hour. • Access to expert radiology and pathology consultant opinion. • Access to paediatric pharmacist advice.	The acutely or critically sick or injured child in the district general hospital (DH, 2006) Head injury: triage, assessment, investigation and early management of head injury in infants, children and adults (NICE, 2007) Services for Children in Emergency Departments (RCPCH, 2007)
	CAMHS	• Liaison arrangements for CAMHS and psychology support capable of rapid response where necessary.	Children's NSF Standard for Hospital Services (DH, 2003) Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care (Scottish Executive, 2005)
	PICU	• Access to PICU for advice. • Any service must function as part of a network with definition of the PICU responsible for providing a service. • Guidelines about use of adult ICU should be agreed with PICU centre. Children cannot be treated in an adult ICU if there is no on-site paediatric department. • PICU retrieval teams responsible for transfer of very sick children.	Services for Children in Emergency Departments (RCPCH, 2007) The acutely or critically sick or injured child in the district general hospital (DH, 2006) Standards document (Paediatric Intensive Care Society, 2001)
	Child protection	• Access to senior child protection advice at all times.	Services for Children in Emergency Departments (RCPCH, 2002)

Table 1: Framework of standards cont..

	Location/Support Service	Specified standard	Supporting evidence/policy
	Transport and transfer (either to inpatient unit or specialist service).	• Appropriately trained professionals must be identified to be responsible for transporting sick children to inpatient sites. • Trained staff must accompany a child being transferred with a level of competence appropriate to the severity of their condition. This must not compromise the on-site service. • Protocols for transfer of children at all levels of dependency must be developed and agreed with local ambulance services.	Services for Children in Emergency Departments (RCPCH, 2007) The acutely or critically sick or injured child in the district general hospital (DH, 2006)
	Other support	• The service must function as part of a network with a defined link unit providing shared protocols, staff rotation and training. • Expert consultant paediatric advice must be accessible at all times. For emergency departments with more than 16,000 child attendances per year, a paediatrician with sub-specialty training in paediatric emergency medicine should be employed. • There must be a named link consultant paediatrician responsible for liaison, contributing to staff training, etc.	The acutely or critically sick or injured child in the district general hospital (DH, 2006) Services for Children in Emergency Departments (RCPCH, 2007)
Minimum workload	Emergency Department	• For a unit with less than 15,000 child and young people attendances per year, appropriate plans must be in place to ensure the ongoing competence and skill mix of clinical staff.	Consensus
Environment	Emergency Department	• Physical separation between children and adult patients. • Breast feeding space available. • Refreshments and baby changing facilities. • Appropriately equipped with suitable play facilities with play specialist input as appropriate.	Services for Children in Emergency Departments (RCPCH, 2007) Children's NSF Standard for Hospital Services (DH, 2003)

Table 1: Framework of standards cont..

	Location/protocol	Specified standard	Supporting evidence/policy
	Inpatient unit	• Dedicated children's facilities. • Safe, suitable and child friendly. • Facilities for play and education with play specialist input as appropriate. • Overnight accommodation for parents.	Children's NSF Standard for Hospital Services (DH, 2003)
	Paediatric Assessment Unit (or other children's short stay observation and assessment service).	• Dedicated children's facilities. • Safe, suitable and child friendly. • Facilities for play and education with play specialist input as appropriate. • Breast feeding space available.	Children's NSF Standard for Hospital Services (DH, 2003)
Clinical protocols	There should be the following agreed protocols.	• Sudden and Unexpected Death in Infants (SUDI). • Child death review. • Management of trauma in children. • Child sex abuse. • Non-accidental injury. • Transfer. • A monitoring system to identify children developing critical illness – an early warning score. • Surgery, including agreed definition of what paediatric surgical care and procedures will be undertaken at each locality, and referral pathways for paediatric general surgery, trauma, ENT and specialist surgical services.	Services for Children in Emergency Departments (RCPCH, 2007) Why Children Die: A Pilot Study 2006 (CEMACH, 2008) Surgery for Children: Delivering a First Class Service (Children's Surgical Forum, 2007)
	Paediatric major incident.	• Hospital major incident plan includes provision for paediatric incidents.	The acutely or critically sick or injured child in the district general hospital (DH, 2006)

3. Discussion

Use of the standards should help to ensure that only proposals for service configuration that will be able to provide safe and effective care can be approved. However, the debate is inevitably complex and changes to one component of a healthcare system will have implications for other areas. Furthermore, well-intended plans often have unintended consequences that may undermine the ultimate success of the reconfiguration.

3.1 Unintended consequences

Experience of reconfiguring services has shown that there are several common unintended consequences:

- Actual attendances and admissions in the new configuration may differ considerably from that estimated during planning, with greater or lesser demand than anticipated.
- There may be staffing and recruitment problems. Some staff may leave as soon as any reconfiguration proposals are announced, others may not wish to work in a new location.
- Assumptions about improved efficiency or performance may not be realistic, particularly if there is little HR and change management support.

3.2 Barriers to reconfiguration

It is also recognised that there are barriers to the reconfiguration process, which may need to be overcome:

- Inadequate communication and consultation.
- Lack of a clear and robust case, which outlines the real reasons for change.
- Lack of information, data and evidence to support proposals.
- Length of time it takes to complete the process.
- Lack of clinical engagement, both at a strategic and frontline level.
- Public resistance to change.
- Implications for access, including parking and public transport.
- Political influences, both locally through MPs and Overview and Scrutiny Committees and at a national level. This includes changes on policy and funding which may alter the viability of plans.
- The need for co-ordination of several reconfiguration proposals.
- Implications of reconfiguration of other services impacting on paediatric reconfiguration.
- Tribalism about clinical skills; there is an overlap between the skills of the primary care, emergency care and paediatric workforce.

3.3 Actions to mitigate or overcome barriers: Managing the transition

Securing strategic support for the reconfiguration from strategic health authorities (SHAs) and PCTs is vital to its success. One mechanism to help drive forward such processes is to define the principal services affected and seek SHA and/or PCT resources to fund a network, which is given the task of organising (on behalf of the commissioning bodies) the generation of options and the consultation. This sort of infrastructure can be a powerful enabling mechanism to foster good clinical engagement and hence clinical credibility for the options to be implemented at the end of the consultation process. The extent of the services embraced by this 'network' can then be clearly defined – for example, do maternity services need to be included or not?

Retaining crucial staff is of vital importance to any such change. It may be helpful therefore to align HR policy across health economies to enable staff to retain secure employment when they need to relocate from one site to another or to more than one site while in transition. For example, staff with specialist skills at a unit that may be closing in the future could be offered contracts with their potential future employer while still working at their original site.

There is a need to align services to maintain safety during transition so that one service does not close before the other is operational. Clearly there are funding implications and PCTs will need to sign up to this at the start of the reconfiguration process to enable double running of services during transition. A local tariff may need to be negotiated to fund such services under Payment by Results (PBR) arrangements.

4. References

A framework of competencies for basic specialist training in paediatrics. RCPCH (2004) www.rcpch.ac.uk/Publications

Advice on Proposals for Changes to Healthcare Services for Children, Young People, Parents and Babies in Greater Manchester, East Cheshire, High Peak and Rossendale. Independent Reconfiguration Panel submitted to the Secretary of State for Health, June 2007. http://www.irpanel.org.uk/view.asp?id=56

Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care. Scottish Executive (2005) www.scotland.gov.uk/Publications/2005/10/2191333/13337

Children's NSF Standard for Hospital Services. DH (2003) www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyand Guidance/DH_4006182

Commissioning Safe and Sustainable Specialised Paediatric Services. An inter-dependencies framework. DH (2008)

Defining staffing levels for children's and young people's services. RCN (2003) www.rcn.org.uk/_data/assets/pdf_file/0004/78592/002172.pdf

Emergency Care Framework for children and young people in Scotland. Scottish Executive (2006) www.scotland.gov.uk/Publications/2006/09/19153348/0

Guidance on Provision of Paediatric Anaesthetic services. Royal College of Anaesthetists. (2005) www.rcoa.ac.uk/index.asp?pageID=477

Head injury: triage, assessment, investigation and early management of head injury in infants, children and adults. NICE (2007) www.nice.org.uk/CG56#documents

Making it Better. (2007) www.bestforhealth.nhs.uk

Modelling the Future – a consultation paper on the future of children's health services. RCPCH (2007) www.rcpch.ac.uk/health-Services/ServiceReconfiguration/Modelling-the-Future

Safeguarding children and young people: roles and competencies for health care staff, an intercollegiate document. RCPCH (2006) www.rcpch.ac.uk/Publications

Services for Children in Emergency Departments. RCPCH (2007) www.rcpch.ac.uk/Publications

Standards Document. Paediatric Intensive Care Society (2001) www.ukpics.org/documents/PICS%20Standards%202001.pdf

Standards for the Care of Critically Ill and Injured Children in the West Midlands. West Midlands Strategic Commissioning Group (2004)

Surgery for Children: Delivering a First Class Service. Children's Surgical Forum (2007) www.rcseng.ac.uk/publications/docs/CSF.html

The acutely or critically sick or injured child in the district general hospital. DH (2006) www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_ 062668

Trauma: who cares? NCEPOD (2007) www.ncepod.org.uk/2007report2/Downloads/SIP_report.pdf

Victoria Climbié Inquiry. Laming (2003) www.vistoria-climbie-inquiry.org.uk/finreport/finreport.htm

Why Children Die: A pilot study (2006). Confidential Enquiry into Maternal and Child Health (May 2008) www.cemach.org.uk

Appendix 1. Working Group Membership

Name	Post	Organisation
Dr Edward Baker	Chair, Paediatricians in Medical Management Committee Medical Director and Consultant Paediatric Cardiologist	RCPCH Guy's and St Thomas' NHS Foundation Trust
Dr Janet Anderson	Honorary Consultant Paediatrician, Joint Clinical Lead, Children, Young People and Maternity Group	West Midlands NHS SHA
Sally Sweeney Carroll	Chair, Patients' and Carers' Advisory Group	RCPCH
Dr Hilary Cass	Registrar Associate Medical Director and Consultant in Paediatric Disability	RCPCH Great Ormond Street Hospital for Children NHS Trust
Dr Stephen Cronin	Former Chair, Paediatricians in Medical Management Committee Clinical Lead for Children's Services, Consultant Paediatrician	RCPCH South Tyneside NHS Foundation Trust
Dr Mark Dyke	Member, Paediatricians in Medical Management Committee Consultant Neonatal Paediatrician and Divisional Clinical Director for Women, Children and Sexual Health	RCPCH Norfolk and Norwich University Hospital NHS Foundation Trust
Dr Carol Ewing	Member, Paediatricians in Medical Management Committee Consultant Paediatrician	RCPCH Central Manchester and Manchester Children's University Hospitals NHS Trust

Dr Patricia Hamilton	President Consultant in Neonatal Paediatrics	RCPCH St George's Healthcare NHS Trust
Dr Jane Hawdon	Member, Paediatricians in Medical Management Committee Clinical Director for Women's Health	RCPCH University College London Hospitals NHS Foundation Trust
Dr Sue Hobbins	Honorary Treasurer Consultant in General Paediatrics	RCPCH Bromley Hospitals NHS Trust
Dr Minoo Irani	Member, Paediatricians in Medical Management Committee Consultant Community Paediatrician	RCPCH Berkshire East PCT
Dr Lisa Kauffmann	Member, Paediatricians in Medical Management Committee Consultant Paediatrician	RCPCH Manchester PCT
Dr Simon Lenton	Vice President for Health Services Consultant Paediatrician	RCPCH Bath and North East Somerset PCT
Dr Jugnu Mahajan	Member, Paediatricians in Medical Management Committee Clinical Director of Paediatrics and Child Health, Consultant Paediatrician	RCPCH Rotherham NHS Foundation Trust

Mr Martin McColgan	Member, Paediatricians in Medical Management Committee Workforce Information Officer	RCPCH RCPCH
Dr Sheila McKenzie	Emeritus Consultant Paediatrician	Barts and the London NHS Trust
Dr Andy Mitchell	Associate Medical Director and Consultant Paediatrician	Great Ormond Street Hospital for Children NHS Trust
Susan Mitchell	Head of Health Services	RCPCH
Dr Gwyneth Owen	Officer for Wales Clinical Director of Paediatrics	RCPCH Carmarthenshire NHS Trust
Dr Peter Powell	Associate Medical Director and Consultant Paediatrician	Bolton Hospitals NHS Trust
Dr Andy Raffles	Clinical Director of Paediatrics	East & North Hertfordshire NHS Trust
Dr David Shortland	Officer for Workforce Planning Consultant Paediatrician	RCPCH Poole Hospital NHS Trust
Dr David Stacey	Member, Paediatricians in Medical Management Committee Consultant Community Paediatrician and Clinical Director Child Health	RCPCH Cumbria PCT

Dr Moira Stewart	Officer for Ireland Consultant Paediatrician	RCPCH North and West Belfast HSS & Public Safety Trust
Dr John Trounce	Regionally Elected Member – South East Thames Consultant Paediatrician	RCPCH Brighton and Sussex University Hospitals NHS Trust
Dr Alison Twycross	RCN Member, Paediatricians in Medical Management Committee Principal Lecturer, Children's Nursing Faculty	RCPCH St George's University of London
Dr Ingrid Wolfe	Child Public Health Research Fellow Paediatrician	RCPCH, LSHTM Whittington Hospital NHS Trust

Appendix 2. FAQs (public focus)

If a children's ward closes, I will have to travel longer distances for inpatient care for my child - won't that be unsafe?

Safety is paramount and the reason for initiating the reconfiguration of children's units is that children are best treated by staff who have the particular skills required to assess and care for them. There are not enough of these staff to sustain all the services currently available in the UK, so there is a need to change services. By reducing the number of units, children can be treated by staff with the best skills for their needs.

In terms of getting to the unit, if your child is feeling very unwell, you would, as in the past, call 999 for an ambulance. Once in the care of the ambulance service your child would have immediate clinical assessment and transport, if necessary, to the most appropriate children's unit. If your child is less unwell, then the time taken to travel to the hospital is likely to be less crucial.

Won't providing urgent care and assessment for children without inpatient facilities be unsafe - what if my child needs to stay overnight or longer?

All emergency departments will be able to receive, assess and manage acutely ill or injured children. Children's assessment units are facilities linked to emergency departments specifically designed for children that can assess a child for short periods of time (up to 12 hours). They are not normally open overnight, and so if a child is still unwell they may be transferred to the nearest hospital with an overnight children's ward. There are usually only a very small number of children who will need to be transferred. It is important that any service that assesses and treats children works closely with other children's services in the area – these networks of services help to ensure that every child gets the high quality care as clinicians share good practice and keep skills up to date.

What will a scaled-down paediatric service look like?

Each service is likely to look very different, depending on the needs of the local population and services available at other nearby paediatric units. Other groups of staff, for example general practitioners and A&E doctors, have skills in assessing sick children. We have to use all these different staff in planning local services, particularly out of hours.

It is difficult to describe a typical unit, but the most basic unit might comprise of a children's assessment unit, staffed by one or two children's doctors with support from children's nurses. The unit might be open 10am –10pm and some children's outpatient clinics might be run on the site. The unit would work closely with other hospitals that provide children's services to ensure that staff share best practice and keep skills up to date.

Shouldn't there always be children's doctors to support the emergency care of children locally?

Quality of care and safety are paramount, and the public should expect and receive high quality care in every setting in the UK. However, the skills a clinician has are more important than specific professional roles. It is important that any clinician treating children, young people, and their families has the skills to assess, treat and communicate effectively. In emergency departments, most care is provided by doctors and nurses trained in emergency medicine who should have specific training in treating children. The majority of children who visit emergency departments will be treated by these staff, and will not need to see a children's doctor. The emergency department staff should be able to decide when a children's doctor is needed, and if necessary transfer the patient to the nearest inpatient children's ward if there is not one on site.

Much of the care of children with urgent problems takes place outside of hospitals, so it is also important that GPs and clinical staff in community settings have the skills to assess and treat children.