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Executive summary

In 2010, the Royal College of Paediatrics and Child Health (RCPCH) published the *Facing the Future* standards setting out ten key requirements to deliver high quality, safe and sustainable acute general paediatric services. The *Back to Facing the Future* audit in 2013 demonstrated that the standards are being used on a daily basis by paediatricians, both to reflect on their own practice, and to advocate for better care for children.

It was always intended that *Facing the Future* would remain live and flexible to changes in the health system and, five years on from their original publication, the RCPCH has conducted a review of the standards and agreed to amend four of them. In summary the changes to the standards are:

Standard one (previously standard six): This standard remains, in the short term, as consultant presence at self-defined peak times. However, the direction of travel and the RCPCH's five year strategic plan is that there should be a consultant present for at least 12 hours a day, seven days a week.

Standard three (previously standard two): This standard has been changed to specify that all children admitted with an acute medical problem are seen by a consultant paediatrician within 14 hours of admission (revised from 24 hours in the original standard).

Standard four (previously standard five): This standard has been changed to specify that there are two consultant led handovers every 24 hours (revised from one handover every 24 hours in the original standard).

Standard eight: The explanatory guidance of this standard has been changed to recognise that there are a growing number of ways of achieving safe, experienced cover and that, where there are rotas comprised of different staff groups, the whole time equivalent on the rota may be modified.

The RCPCH believes that these standards will bring a level of consistency to what is currently quite a variable pattern of practice. The intention is to ensure that every child is seen in a timely manner by a suitably experienced doctor. Increased consultant presence will not only improve the quality and safety of care but will also provide additional training opportunities, though care is needed to ensure that this is not at the cost of limiting the development of independent decision making skills.

The standards cannot be met with the current workforce and the current number of inpatient units. The five key recommendations made in the original report are even more crucial with these revisions to the standards:

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Facing the Future represents a standard of care which children and their parents and carers can expect from the doctors looking after them. We hope that paediatricians will see them not just as standards to strive toward, but as a lever to continue to improve the safety, quality and sustainability of services.

1. Background

In 2010, the RCPCH developed and published *Facing the Future: Standards for Paediatric Services*[1] which outlined ten minimum standards for acute, general paediatric care. These are set out in the box below.

Facing the Future Standards 2010

1. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.
2. Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent sta , speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the rst 24 hours.
3. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
4. All short stay paediatric assessment units have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
7. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
8. All general acute paediatric rotas are made up of at least ten whole time equivalents, all of whom are European Working Time Directive compliant.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

3. Revised service standards

The following chapter sets out ten key service standards for acute, general paediatric services. They are underpinned by three key principles:

Consultants are responsible and accountable for the children under their care.
Children must be seen by the correct person, with the appropriate skills, as soon as possible.
There must be sufficient staff across all rotas to deliver the standards.

The standards are first listed overleaf and then an explanatory guide to each one is provided in the next chapter.

Throughout the standards the term 'child' or 'children' is used to refer to infants, children and young people under the age of 18 across the UK.

Facing the Future Standards 2015

1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.

3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member sta is concerned.

4. At least two medical handovers every 24 hours are led by a consultant paediatrician*.

5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.

6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.

7. All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.

8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

10. All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.

* or equivalent sta , associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota

4. Explanatory guide to the standards

Standard one

Standard three

Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member sta is concerned.

The RCPCH recognises that implementation of this standard will need consultant led ward rounds twice a day, seven days a week. The RCPCH believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality of care[4, 5].

The consultant should be aware of the possible impact of this standard on the training of paediatric trainees and steps should be taken to use clinical assessments/interventions in supporting trainees to develop decision making skills. Fdetric

Standard six

Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.

Standard nine

5. Rationale for the changes to the standards

Since the publication of the *Facing the Future* standards in 2010 much has happened both in the NHS and the wider economic and social environment in which it operates. England has seen the implementation of the *Health and Social Care Act 2012*, which has signi cantly reshaped the NHS, and the 'Nicholson challenge' of £20 billion in e ciency savings. Services across the UK continue to operate in a tight economic climate and with an increasing number of emergency department attendances and hospital admissions. The *NHS England Five Year Forward View*[9] published in October 2014 recognised that action would be needed on three fronts: demand, e ciency and funding.

The UK is also facing considerable challenges in continuing to provide safe, sustainable services that meet the needs of children and their families. Workforce pressures, medical and technological advances and children's changing needs and expectations all contribute to the need for change.

The *Francis report* into the tragic events at Mid Sta ordshire NHS Foundation Trust[10] and the

The potential impact of these standards on the training of paediatricians has been discussed in detail with the RCPCH Trainees Committee, which is supportive of the proposed changes. Their view is that increased consultant presence will not only improve the quality and safety of care but will also provide additional training opportunities, for example, during handovers and ward rounds, though care is needed to ensure that this is not at the cost of limiting the development of independent decision making skills. Within the standards we have highlighted the importance of consultants considering, discussing and meeting the training needs of paediatric trainees.

Standards two, five, six, seven, nine and ten have not been significantly changed (although the order has been altered).

Rationale for changes to standard one

A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.

The *Back to Facing the Future* audit highlighted that the standards are not being met as regularly at weekends and evenings as they are between the hours of 9am and 5pm. This means that at times of peak activity, when you would expect the standard of service to be at its most robust, the most senior and experienced sta are not always present. This is consistent with recent news stories concerning the service that the NHS provides during evenings and weekends and with the ndings of the Keogh Review on seven day working[13].

We fully recognise the pressures on acute paediatricians within the current structure and con guration of services, but believe that the audit demonstrates that we have to be prepared to re-examine the way in which we deliver care. It is essential that paediatric services are organised around the child's needs and that paediatrics is a 24 hours a day, seven days a week specialty.

In 2010 the *Temple report*[14] concluded that consultant-delivered care was the only viable model for the future of medical care in the UK. There were a number of reasons for this but most importantly the simple fact that consultants 'make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality'. The *Temple report* de nes consultant delivered care as '24 hour presence, or ready availability' and it is this model of service that underpins many of the *Facing the Future* service standards.

The debate over consultant delivered care has progressed since 2010, with the Academy of Medical Royal Colleges (AoMRC) publishing *The Bene ts of Consultant-Delivered Care*[15] in 2012. This looked at the available evidence and concluded that a consultant led service resulted in rapid and appropriate decision making, improved outcomes for patients, more e cient use of resources, improved GP access to the opinion of a fully trained doctor, satis ed patient expectations of access to appropriate and skilled clinicians and information, and bene ted the training of doctors.

In 2012, the RCPCH published *Consultant Delivered Care: An evaluation of new wa s of working in paediatrics*[16]. The report concluded that children would receive better care if they had 24/7 access to a consultant or equivalent senior doctor and that the 'resident shift working consultant model is central'.

This standard has been moved to be the first of the *Facing the Future* standards, on the basis that increased consultant presence and availability is necessary to be able to deliver the rest of the standards.

The standard is designed to ensure that a consultant paediatrician is present at peak times with flexibility to take account of local patterns of activity. This standard will, in the short term, remain as consultant presence at self-defined peak times. However, the direction of travel and the RCPCH's five year strategic plan is that there should be a consultant present for at least 12 hours a day, seven days a week.

Rationale for changes to standard three

The RCPCH recognises that implementation of this standard will need consultant led ward rounds twice a day, seven days a week. The RCPCH believes this is necessary as there is good evidence that regular consultant review can decrease length of stay for patients and improve quality of care[20, 21].

Findings from the audit indicate that 31% of admissions are already being seen by a consultant within 12 hours. 39% of admissions were not seen by a consultant within 12 hours (with another 22% being discharged in under 12 hours and 8% unknown). The standard has already been introduced for paediatric services in London[22] and the Royal College of Physicians[23] and Royal College of Surgeons[24] specify consultant review within 12 hours.

Rationale for changes to standard four

Rationale for changes to standard eight

All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.

6. Implementation of the standards

This revision of the *Facing the Future* standards, and particularly the change from 24 hours to 14 hours for children to be seen by a consultant, marks a move towards ensuring that paediatrics is a 24 hours a day, seven days a week specialty and that services are organised around the child with quick access to an expert opinion.

The RCPCH accepts that implementation of these standards will necessitate a greater degree of consultant presence than has been the case but believes that these standards will bring a level of consistency to what is currently quite a variable pattern of practice. The RCPCH believes that the direction of travel (over the next ve years) is to implement 12 hour consultant presence, seven days a week.

These standards should complement a clinical director's assessment of the needs of their service. We want to support and prompt conversations with units that do not meet the standards and to facilitate discussions between neighbouring units on how the standards might be met by working as a bigger team in network con gurations.

To deliver the revised standards, it is clear from the response to the consultation exercise that general acute consultant numbers would need to increase. The standards cannot be met across the UK with the current workforce and the current number of inpatient units and the ve key interlocking messages in the original *Facing the Future* report are even more crucial with these revisions to the standards:

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Patient safety

The RCPCH is also actively involved in patient safety initiatives, for example, the Infant, Children and Young People's Patient Safety Expert Group hosted by NHS England which is developing a consistent paediatric early warning score and patient safety thermometers. The RCPCH has also developed links with and presented at a recent meeting of the Paediatric Collaborative in Northern Ireland, which aims to facilitate the provision of high quality, safe paediatric care to ensure the best outcomes for children. The Scottish Paediatric Safety Programme was established in 2009 and aims to support paediatric sta to improve the quality and safety of paediatric care.

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