Emergency Care Framework for Children and Young People in Scotland
Emergency Care Framework for Children and Young People in Scotland
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Foreword

This *Emergency Care Framework* builds on our commitments in *Delivering for Health* to improve the quality of care for children and young people in Scotland. They deserve the best possible care that we can provide, whether it is in a rural or urban area, in an appropriate setting, delivered by staff who have the necessary skills to treat them effectively.

The work undertaken by the Children and Young People’s Health Support Group and Emergency Care Working Group led by Dr Tom Beattie represents the most extensive review ever undertaken of these services. This approach builds on the already existing network of services provided throughout Scotland and makes clear recommendations on how these services are planned and delivered in the future.

The action plan describes a clear and articulate way forward to deliver improvements in care. Importantly it describes the services that should be available throughout Scotland and the steps that Health Boards should take over the next three years to deliver the improvements highlighted in this document. The change process will be supported by an educational framework for all staff ensuring that they have the necessary skills and competencies to deliver care. This process will be led by NHS Education Scotland working with NHS Boards and Regional Planning Groups.

This document represents an important step in the Scottish Executive’s commitments outlined in *Delivering for Health* to establish a health service for children and young people which is fit for the 21st Century.

Lewis MacDonald  
Deputy Minister for Health and Community Care
This *Emergency Care Framework* represents the latest service action plan to deliver improvements in the way we provide care to our children and young people in Scotland. It has been through a very detailed development process led by Dr Tom Beattie and his colleagues and was incorporated in building a *Health Service Fit for the Future* and the Scottish Executive’s response *Delivering for Health*.

The key messages made by carers, patients and staff during these exercises were that we need to ensure that staff have the core skills and competencies, care should be delivered in an appropriate environment and communication between different professionals and services has to be improved. We also have to recognise that much of the care provided to children and young people is provided not in specialist children’s hospitals, but in the community by staff who deal mainly with adults in primary care settings or in hospital adult Accident and Emergency Departments.

In response to these issues the Children and Young People’s Health Support Group has developed this *Emergency Care Framework*. To support the delivery of the action plan NHS Education Scotland has developed a core skills and competencies framework which will be rolled out over the next three years ensuring that all staff will be able to recognise and treat more effectively children and young people who present for care.

The action plan attached to this framework is challenging and the Children and Young People’s Health Support Group will continue to work with the Scottish Executive, NHSScotland and people who use services to ensure it delivers the improvements in care we expect.

**Malcolm Wright**  
Chair  
Children and Young People’s Health Support Group
Executive Summary

1. The face of emergency care, with the traditional role of General Practitioners (GPs) and hospital Accident and Emergency (A&E) Departments is changing. Nurse led minor injury facilities, out-of-hours services, NHS 24 and paramedic services have increased the choice and availability of emergency care providers.

2. Children and young people make up approximately 20% of the Scottish population but represent a significant proportion of Accident and Emergency Department attendances (25-30%) and calls to out-of-hours GP services. Children are more likely to be admitted to hospital as emergencies than as planned admissions. In spite of this a significant number of hospitals lack staff qualified in the care of children and young people and do not provide a child-friendly environment.

3. Young people have particular needs which are not always recognised or catered for. Often they are treated in a young paediatric setting with babies and young children or they receive emergency care in an adult dominated environment.

4. The emergency care situation can be a particularly anxious and stressful time for children and young people. This anxiety can be reduced by providing a welcoming and appropriate environment with staff who are confident in communicating with and treating children and young people.

5. The variation in population density in Scotland is such that a ‘one size fits all’ approach to emergency care is not tenable. An Emergency Care Framework for children and young people has been developed for the different types of emergency care facility available (Figure 1). While minor injury facilities provide a convenient local solution in many areas they can lack the full services and expertise of an A&E Department, especially in terms of caring for children and young people. It is important that health care professionals and the public view their role realistically, understand their limitations and use them appropriately.

6. The framework provides a template for optimal emergency care provision for children and young people based on a four level model of care which is summarised below:

   • **Level 1**: The first contact for an acutely ill/injured child or young person with health services is often their primary care provider (general practice), an out-of-hours service, ambulance paramedics and increasingly, through telephone contact with NHS 24.

   • **Level 2**: (i.e. general hospitals with an Accident and Emergency Department but without a Paediatric Inpatient Unit) may have facilities for assessing and observing children and young people over a period of time prior to making a decision about whether to discharge or not. However these facilities are often open for a limited number of hours during the day and children and young people who require admission need to be transferred to the local Inpatient Unit.

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2. Emergency Health Services for Children and Young People: A guide for commissioners and providers, C Hogg, Action for Sick Children, 1997

3. Children’s Attendance at a Minor Injury/Illness Service, Royal College of Paediatrics and Child Health, February 2002
EXECUTIVE SUMMARY

- **Level 3**: Emergency care should be available from a general hospital with a paediatric in-patient unit which will have significantly more capacity to manage the unwell child or young person than a hospital without such facilities.

- **Level 4**: Can be provided by specialist children’s hospitals or units, which provide paediatric intensive care and/or High Dependency Care, paediatric surgery and a range of specialist services and advice, all of which are available on site.

Figure 1: Tiered Framework for Emergency Care for Children & Young People

7. It is recognised that it can be beneficial to co-locate children and young people’s services with adult services on the same site. This would be of particular benefit for emergency care situations that involve adult and child members of the same family.
Summary of Recommendations

8. Regional Planning Groups and NHS Boards should identify the level of care that should be provided at each of their emergency care sites in accordance with the proposed *Emergency Care Framework for Children and Young People in Scotland*.

9. All emergency care sites should provide a safe and non-threatening environment for the treatment of children and young people and staff providing care in emergency care sites should have a core set of skills and competencies to provide care to children and young people and access to support and advice from a registered children's practitioner on a 24/7 basis.

10. A standard assessment method should be developed for use with children and young people at all emergency care facilities. This assessment method should recognise the severity of illness or injury, the degree of pain and distress and the potential vulnerability of the child or young person.

11. National guidelines and best practice statements should be developed for the management of common acute and potentially life threatening conditions for children and young people.

12. A multi-professional emergency care competency system should be developed by NHS Education for Scotland for practitioners who provide emergency care for children and young people. Once developed competencies should be maintained and updated.

13. The development of expanded roles for emergency care practitioners should consider the needs of children and young people and be undertaken under the guidance of NHS Education for Scotland and the relevant professional bodies.

14. NHS Boards should clearly identify which sites in their area will at all times provide emergency advanced imaging facilities for children and young people. This information should be shared with NHS 24, primary care teams, out-of-hours services and the Scottish Ambulance Service.
Caring for Children and Young People
Introduction

1. Scotland is a small nation with distinctive challenges. Its population of just over five million people is dispersed across a very variable geography. Although a large proportion of the population live in the urbanised central lowlands, a significant number live in remote and rural communities.

2. The National Health Service in Scotland faces a difficult challenge to ensure that everyone can access the most appropriate medical care at the right time in the right place. This is particularly challenging for child health services where the numbers using certain services can be very small.

3. For the purposes of this report, emergency care for children and young people is defined as any unscheduled care provided by a trained health care practitioner. This care can consist of advice and/or treatment and can be required at any time of the day or night. This may be completed simply and quickly or may be the start of further ongoing care.

Emergency Care

4. The face of emergency care is changing. Traditionally general practitioners (GPs) and hospital Accident and Emergency (A&E) Departments have been the main focus for emergency care services for children and young people. An increasing number of nurse led minor injury facilities, out-of-hours services and paramedic services have changed the choice and availability of emergency care providers.

5. Scotland now has a new partner in emergency care – NHS 24. This telephone advice service began operation in May 2002. NHS 24 provides a new method through which people can access emergency care facilities out-of-hours in addition to providing medical advice and information services.

6. Children and young people make up approximately 20% of the Scottish population but represent a significant proportion of A&E Department attendances (25-30%) and calls to out-of-hours GP services. Children are more likely to be admitted to hospital as emergencies than as planned admissions. In spite of this a significant number of hospitals lack staff qualified in the care of children and young people and do not provide a child-friendly environment.

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5 Emergency health services for children and young people: A guide for commissioners and providers, C Hogg, Action for Sick Children, 1997
7. In the past there have been a number of notable incidents where services have collectively failed to meet the needs of children and young people. The poor outcomes from child heart surgery at Bristol Royal Infirmary\(^6,7\) and the deaths of Victoria Climbie\(^8\) and Caleb Ness\(^9\) are examples of this. It is therefore important that we never become complacent regarding the services we provide for children and young people and that we actively seek opportunities to improve these services wherever possible.

The Emergency Care Needs of Children and Young People

8. It is essential to acknowledge that children are not small adults and recognise they relate differently to the outside world. The emergency care situation can be a particularly anxious and stressful time for children and young people. This anxiety can be reduced by providing a welcoming and appropriate environment with staff who are confident in communicating with and treating children and young people. The sights and sounds of a typical adult emergency site can be disturbing and upsetting for children and young people and it is vital that staff recognise this.\(^10\)

9. For the purposes of this *Emergency Care Framework (ECF)* the advisory group use the term ‘young people’ to include patients from eleven to sixteen years. However it is recognised that the issues of this review could also be relevant for young people over sixteen years.

10. Young people have particular needs which are not always recognised or catered for. Often they are treated in a young paediatric setting with babies and young children or they receive emergency care in an adult dominated environment. It is important to recognise that the development stage of a young person and not just their age should be considered when identifying the most appropriate emergency care environment.

11. This *ECF* recognises the principle that high quality emergency care should be available for all children and young people irrespective of where that care is provided in Scotland. While the level of care provided will be site dependent, all emergency care sites which see children and young people, must have safe and suitable facilities staffed by practitioners who are capable and confident in treating children and young people.

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\(^6\) Learning from Bristol: The Department of Health’s response to the report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995, Stationery Office, January 2002

\(^7\) Response to recommendations from the report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995, Scottish Executive Health Department, January 2002

\(^8\) The Victoria Climbie Inquiry, Stationery Office, January 2003


\(^10\) Paediatric Emergencies, TF Beattie, GM Hendry, KP Duguid, 1997
Ongoing Commitment by the Scottish Executive

12. The Scottish Executive is committed to improving the future health of children and young people. To help address the challenges in improving the health of Scottish children and young people, two key forums have been established to champion their interests. Their roles are highlighted below:

• A cross cutting Children and Young People Cabinet Delivery Group has been set up to ensure an integrated approach to children and young people's issues across the Executive. This Group is chaired by the Minister for Education and Young People.

• A multi-agency Ministerial expert advisory Children and Young People’s Health Support Group (CYPHSG), formerly known as the Child Health Support Group, which has been asked to produce an Action Framework for Children and Young People's Health in Scotland.

Review of Emergency Care

13. The review was taken forward by a working group on behalf of the Child Health Support Group. The review group was chaired by Dr Tom Beattie, Lead A&E consultant from the Royal Hospital for Sick Children in Edinburgh and contained representatives from across the health service and the voluntary sector in Scotland. Key management support was delivered by Robert Stevenson, CYPHSG Project Director, Mary Boyle, Programme Director, NHS Education Scotland and Fiona Page, Project Manager, Scottish Executive Health Department (SEHD) and the staff of the Child and Maternal Health Unit. A full list of members of this group is contained in Annex A of this report.

14. A survey questionnaire was sent to each NHS Board area to identify current emergency care provision for acutely ill and injured children and young people. Seventy-four emergency care sites across Scotland responded to this questionnaire and this formed the basis of the Review Report which was circulated for comment.

15. The comments received during the review and the consultation process for Building a Health Service Fit for the Future have been included in this, the Emergency Care Framework for Children and Young People in Scotland.
Emergency Care for Children and Young People in Scotland – The Key Drivers
Change in the NHS in Scotland

16. There are a number of drivers for change that are impacting on the care of children and young people and the delivery of services by the NHS in Scotland that require consideration in order to understand the pressures on emergency care provision. These are covered in more detail in the following section and include:

- Workforce
- Trends in society and healthcare
- Public health issues
- Rural health

Workforce

17. The European Working Time Directive introduced limits to the periods of time people can work to help improve the health and safety of workers and the work/family life balance. One of the limits introduced is a maximum working week of 48 hours and this has been a major driver for service redesign in NHS services. These rules have already been applied to consultants and non-medical staff and there is phased introduction planned for junior medical staff from August 2004.

18. These working time limitations together with the New Deal Contract are focusing hospital care services towards a service provided by consultants. As a result, junior doctors will work a maximum average of 48 hours per week and will receive a more structured approach to their training.

19. There are also other changes proposed for junior doctors. Modernising Medical Careers introduces a new competency based foundation programme for junior doctors. The report chaired by Sir John Temple in Securing Future Practice recognises that the current approach to medical training requires redesign if the NHS is to deliver the required outcomes for a patient focused service. Potential solutions include the development of more flexible multi-disciplinary teams and reorganisation of out-of-hours services.

20. The new Consultant Contract introduced in 2004 is modernising the way consultants work within the NHS. It limits the numbers of hours worked by individual consultants and directs more focus towards the delivery of direct clinical care. The new contract should deliver higher standards of clinical governance and provide a more effective planning system for scheduling consultant activities within the NHS.

21. The new General Medical Services Contract will provide General Practices with the opportunity to opt in or out of some health care services including out-of-hours care. This new contract process will reward practices for achieving specified quality outcomes and is expected to deliver improved quality of care for patients. Changes are beginning to happen in the way in which out-of-hours services are organised including centralisation of services. It will be important in these circumstances, that staff are fully trained and competent in recognising and delivering the needs of children, young people and their parents/carers.

11 Securing Future Practice: Shaping the New Medical Workforce for Scotland, Scottish Executive, 2004
22. **Agenda for Change** is a new pay system which applies to the majority of NHS staff in Scotland – all directly employed NHS staff except very senior managers and those covered by the Doctors and Dentists Pay Review Body. This system is working towards harmonisation of service conditions for NHS staff with implications for pay, restructuring and grading of posts. Overall the new system aims to establish a framework which meets the demands of the health service and rewards staff effectively.

23. In addition to planning how to solve current and future workforce gaps, a number of workforce projects are ongoing. The Hospital at Night Model proposes that effective clinical care at night is best achieved through the use of multidisciplinary teams who collectively have the full range of skills and competencies to meet patients’ immediate needs. Other work on Ambulatory Care Models is based on the principle of rapid patient access to fast track diagnosis and treatment.

### Trends in Society and Health Care

24. The number of children and young people in Scotland is declining. Until recently forecasts predict a reduction from approximately one million children and young people in Scotland to around three-quarters of a million by 2023. This has recently been revised – with an increase in the birth rate and increased migration the figure has been revised with the decrease not expected until 20 years later.

25. Sociological factors are also dynamic. Traditionally the nuclear family provided substantial support for childcare and child rearing including dealing with unexpected illness at home. Now there is increased diversity in family structures that requires different health care support mechanisms.

26. Advances in medical care and technology are contributing to increasing numbers of children and young people surviving longer with complex care needs. It is important that these children and young people have personalised, established care pathways for emergency care, which include direct referral to specialist staff where appropriate.

### Public Health Issues

27. Childhood obesity and the need for healthy eating is an area of concern. Current data suggests that a third of children aged twelve years are overweight and a fifth of toddlers are overweight before their fourth birthday.

28. Poor physical activity levels in children are also giving cause for concern with thirty percent of boys and forty percent of girls not undertaking the amount of physical activity required for good health.

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13. Findings and Recommendations from the Hospital at Night Project, NHS Modernisation Agency, April 2004
15. Population projections and estimates from the General Register Office for Scotland, June 2004
17. Health in Scotland 2003, NHSScotland, 2004
29. It is estimated that almost half of the children living in the UK are exposed to tobacco smoke at home. Second-hand smoke (passive smoking) increases the possibility of respiratory infections in children and young people and is also associated with ear infections, possible cardiovascular impairment and behavioural problems. It increases the severity of asthma and is a risk factor for new cases in children. Childhood asthma remains a long-term health problem and requires significant health care support.\(^\text{18}\)

30. Drug misuse continues to be a problem with young people and 382 drug-related deaths were reported in 2002. The needs of children and young people with parents who misuse drugs and have alcohol problems require particular attention with estimates of at least forty thousand children affected by parental drug abuse in Scotland.\(^\text{19}\)

31. Self-harm is a growing area with direct implications for emergency care. Over 7,000 people are treated in hospital each year following episodes of non-fatal deliberate self-harm.\(^\text{20}\) The number of young people, especially teenage girls who are treated for self-harm is of particular concern.

32. Injury remains a leading cause of death and disability in the UK, particularly with children and young people.\(^\text{21}\) Road traffic accidents and injury at play contribute substantially to the workloads of emergency services. Within the home setting, poisoning, burns, scalds and fingertip injuries form a significant emergency care workload.

Rural Communities

33. The widespread nature of the remote and rural population in Scotland provides particular challenges for the provision of emergency health care. It is not logistically possible to provide fully staffed paediatric emergency departments in every locality and the particular challenge for NHSScotland is how to provide effective emergency care in local communities.

34. Transport is a key issue for emergency care. Wherever possible emergency care for children and young people should be provided as close to home as possible. However at times the child or young person will require advanced medical care. This can be achieved by transporting the sick child or young person and their family to a more advanced care centre.

35. The ability to deliver health care remotely using information and communication technologies is known as telemedicine. This can be of benefit throughout Scotland especially in remote and rural areas. Tele-consultations and digital image transfer in particular can enhance the provision of emergency medical services.

36. Emergency care sites should utilise this technology to support the care of children and young people, particularly in remote and rural areas.

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\(^{18}\) Trend in occurrence of asthma among children and young adults, G Russell et al, British Medical Journal, October 1997; 315: 1014-1015

\(^{19}\) Hidden Harm: Responding to the needs of children of problem drug users, Report of an inquiry by the Advisory Council on the misuse of drugs, June 2003

\(^{20}\) Choose life: A national action plan and strategy to prevent suicide in Scotland, Scottish Executive, October 2004

\(^{21}\) Injury surveillance in UK hospitals: a brief overview, Scottish Centre for Infection and Environmental Health (SCIEH) Weekly Report, 16 March 1999
Where Should Children and Young People Receive Emergency Care?
A Framework for Emergency Care

37. The variation in population density in Scotland is such that a ‘one size fits all’ approach to emergency care is not tenable. It is important that NHS Boards align their emergency services to meet the needs of their local populations. This may mean working with adjoining NHS Boards to integrate care across organisational boundaries.

38. An Emergency Care Framework for Children and Young People has been developed for the different types of emergency care facility available. This is illustrated in Figure 1 below and a fully detailed framework is contained in Annex B. This Emergency Care Framework builds on current local structures and provides a template for optimal emergency care provision for children and young people. It identifies the different levels of emergency care provision, the staff required to support this care and the nature of the services delivered at each level.

Figure 1: Tiered Framework for Emergency Care for Children & Young People
The framework provides a template for optimal emergency care provision for children and young people based on a four level model of care which is summarised below:

- **Level 1**: The first contact for an acutely ill/injured child or young person with health services is often their primary care provider (general practice), an out-of-hours service, ambulance paramedics and increasingly, through telephone contact with NHS 24.

- **Level 2**: (i.e. general hospitals with an Accident and Emergency Department but without a Paediatric Inpatient Unit) may have facilities for assessing and observing children and young people over a period of time prior to making a decision about whether to discharge or not. However, these facilities are often open for a limited number of hours during the day and children and young people who require admission need to be transferred to the local Inpatient Unit.

- **Level 3**: Emergency care should be available from a general hospital with a paediatric in-patient unit which will have significantly more capacity to manage the unwell child or young person than a hospital without such facilities.

- **Level 4**: Can be provided by specialist children’s hospitals or units, which provide paediatric intensive care and/or High Dependency Care, paediatric surgery and a range of specialist services and advice, all of which are available on site.

It is recognised that minor injury facilities provide a convenient local solution in many areas. However, they can lack the full services and expertise of an A&E Department, especially in terms of caring for children and young people. It is important that health care professionals and the public view their role realistically, understand their limitations and use them appropriately.22

It is recognised that it can be beneficial to co-locate children and young people’s services with adult services on the same site. This would be of particular benefit for emergency care situations that involve adult and child members of the same family.

Children and young people may be seen for the first time at any one of these four levels. The majority of children and young people can be managed where they first present. However, some will need to go to sites which provide a more advanced level of care for appropriate diagnosis and treatment.

The adoption of this framework should allow greater clarity about the optimum level of emergency care which a site should provide for a child or young person. For example, a child with a significant head injury who is otherwise stable should be taken to a hospital, which can provide CT scanning to enable accurate diagnosis.

It is recommended that emergency services for children and young people be aligned and provided for according to this multi-professional framework. In particular, NHS Boards should decide which emergency care facility is the major emergency care provider for children and young people in their area.

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22 Children's Attendance at a Minor Injury/Illness Service, Royal College of Paediatrics and Child Health, February 2002
45. This information should be shared with NHS 24, primary care teams, out-of-hours services and the Scottish Ambulance Service to ensure that children and young people are directed to the most appropriate emergency care site. This may sometimes mean bypassing lower level emergency care sites to access the appropriate care level required.

46. Underpinning this emergency care framework is the need to have the appropriate staff competencies and equipment in place. This need applies equally across facilities including the Scottish Ambulance Service and NHS 24.

47. When health care services are reconfigured in an area, care should be given to addressing the needs of children and young people. In particular, a continuous care pathway for emergency care for children and young people should be an explicit component of any emergency care service reconfiguration.

The Needs of Children and Young People

48. Children and young people should receive emergency care within a safe environment that can cater for their needs. It can be difficult to provide this care optimally in an adult care environment, which can be frightening and bewildering for young children.

49. By contrast, dedicated care environments for children and young people will have specialised staff and specific equipment and facilities. These dedicated care environments are best suited to providing emergency care for children and young people who are less than 16 years of age.

50. It is recognised that at times children and young people will attend adult emergency care facilities. If these emergency care facilities are to provide care for children and young people they must provide a safe and non-threatening environment. In some facilities, this can be provided by having separate designated waiting and treatment areas for children and young people. At other sites where this is not possible, appropriate screening, segregation and prioritising treatment will help.

51. Emergency care sites must have equipment suitable for children and young people. While the level of care available will dictate what equipment is used, in all cases staff should be trained in its use, the equipment should be adequately maintained and appropriate infection control measures should be followed.

Children and Young People with Long-Term Care Needs

52. An increasing number of chronically ill children are surviving into young adulthood. Consequently, there is a growing need for specialist care to ensure a seamless transfer and transition from children’s to adult health care services, which should consider emergency arrangements. During the transition phase, when care may be shared prior to final transfer of responsibilities, it must be clear where the young person wishes to receive emergency care. This information should be shared with NHS 24, their primary care team, their out-of-hours services and the Scottish Ambulance Service.

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Adolescent transition care: Guidance for nursing staff, Royal College of Nursing, 2004
The Role of Registered Children’s Nurses

53. Children, young people, families and the public expect that nurses, doctors and other professionals who are responsible for children and young people’s health will be appropriately qualified and experienced.\(^2^4\)

54. The Royal College of Nursing supports the provision of registered children’s nurses at all facilities that provide emergency care for children and young people. It is recognised it can be difficult for smaller facilities to recruit, retain and maintain the skills of registered children’s nurses where the service principally involves adults and where children present in small numbers. However, the adoption of different deployment mechanisms to make better and wider use of their skills through shared services and more flexible, innovative working practices can in part address this, especially in smaller, more rural service areas.

55. There are also opportunities and new developments in extended roles for registered children’s nurses\(^2^5\) as paediatric nurse practitioners and in community children’s nursing teams. These new roles can be used to support emergency care facilities during the shifts where children and young people are most expected to attend.

56. It is recognised that in the short to medium term there may be difficulties in providing full cover by registered children’s nurses in emergency care facilities designated at Levels 3 or 4. Therefore it may be some time before this standard can be uniformly met.

57. Similarly Level 2 A&E Departments should work towards providing suitably trained and experienced nurses on all shifts where children and young people can be reasonably expected. Where possible it would be desirable to have this cover provided by registered children’s nurses, especially in those facilities seeing significant numbers of children and young people.

58. Where there are shortfalls in provision of registered children’s nurses, it is essential to compensate for this by having nurses that are capable and comfortable in dealing with the needs of children and young people. These needs should be met by providing additional training and practical experience for registered adult nurses.

\(^2^4\) Preparing nurses to care for children and young people, Royal College of Nursing, April 2003
\(^2^5\) Services for children and young people: Preparing nurses for future roles, Royal College of Nursing, October 2004
Vulnerability in Children and Young People
59. Defining vulnerability in children and young people is challenging. Further definitions may be obtained from Scottish Executive guidance on the implementation of Health for all Children report (HALL 4)\textsuperscript{26}. The outcomes from the consultation on Getting it Right for Every Child will help to strengthen the identification of vulnerable children and young people. However we need to recognise that in the emergency care context some children may be at particular risk of injury or harm because of personal, family or social factors. In terms of emergency healthcare provision, indicators of vulnerability can include:

- Non-accidental injury
- Neglect by parents or carers
- Recurring accidental injury
- Alcohol, drug or solvent misuse
- Sexual abuse
- Self harm or reckless behaviour

The areas that we focus on in this section include:

- Child protection
- Self-harm
- Emergency care records
- Recurring attendance by children and young people

### Child Protection

60. It is important that health care practitioners are skilled and knowledgeable in child protection in order to identify vulnerability indicators in children and young people. Some practitioners will also need more specialist knowledge and skills including inter-agency training. In addition to having trained staff, all emergency care sites must know what to do when there are concerns about risk to a child or young person. This will include who to consult and inform, the information that should be recorded and the correct way to do this. Staff should have access at all times to specialist advice and support to help manage complex child protection cases and in all cases, there must be appropriate management and onward referral.

61. The survey questionnaire responses indicated that 93% of emergency care sites have written child protection policies. However only 61% of emergency care sites have staff specifically trained to deal with child protection issues and only 46% of sites have trained staff available at all times.

\textsuperscript{26} Health for all children: Guidance on implementation in Scotland, Scottish Executive, 2004
Self-Harm

62. Self-harm is an area of vulnerability that gives particular concern. Children and young people presenting with possible/actual self-harm have complex needs. Staff must be empathetic to their needs and have the competencies to recognise their vulnerability. Their treatment is more complex than with adults and there must be appropriate referral mechanisms in place to refer on to Child and Adolescent Mental Health Services (CAMHS).

63. The survey questionnaire responses indicated that only 28% of emergency care sites have protocols for dealing with self-harm, alcohol and/or drug misuse in children and young people. While the majority of responses indicated emergency care sites have access to CAMH services, a number noted that access to these services was not available at all times.

64. When staff are unable to determine personal details for a child or young person there should be a guideline for staff to follow to ensure the ongoing safety of the child or young person. This should apply in any situation involving a potentially vulnerable child or young person and it is particularly important in the case of self-harm.

Emergency Care Records

65. Children and young people may access health care and advice from a number of emergency care sites across Scotland. Contacts with these emergency care sites should be recorded and notified to the appropriate primary care team.

66. Primary care teams are best placed to build up a complete picture of a child or young person and their family/care environment and can help ensure identification and follow up of possible vulnerability.

67. It is recognised that at times a child or young person seeking emergency medical advice and/or treatment may be unable to provide details of their primary care provider. There will also be occasions where a child or young person is not registered with a primary care team.

68. In these situations, emergency care staff must understand the procedures to follow to ensure that an attendance by a child or young person is documented. This protocol may involve contacting local primary care providers to initiate registration of the child or young person.

Recurring Attendance by Children and Young People

69. Recurring attendance of children and young people for emergency care or advice may indicate particular vulnerability. Therefore all emergency care sites must be able to identify recurring attendance.

70. The questionnaire responses for this review indicated that overall 53% of emergency care facilities in Scotland can identify repeat attendances by children and young people (70% for large hospitals and children’s hospitals and 41% for community hospitals, minor injury facilities and medical centres).

71. The difficulty in identifying recurring attendance can be attributed in part to the existence of paper based record systems which do not easily lend themselves to data collation.
There are plans for new electronic record systems within A&E Departments which will facilitate improved information flow between hospitals, primary care providers and out-of-hours services. However this is a long term aim and all emergency care sites need to act now to ensure that they have a system in place which helps safeguard children and young people. This should include a mechanism to detect attendance by children and young people on a local child protection register.

72. Where recurring attendance gives cause for concern, emergency care staff should know what action they should take, who needs to be informed and consulted and details of the appropriate referral network.

73. Primary care have a key role in this process and their record collation should include all notifications of contact by NHS 24, out-of-hours services and the Scottish Ambulance Service.
Clinical Care of Children and Young People
74. The review process identified a number of areas around the clinical care of children and young people which have been summarised below and included in the action plan in Annex C. The areas include:

- Recognition of illness/injury in children and young people
- National standards/guidelines
- Clinical care organisation
- Imaging investigations
- Short stay/ambulatory assessment facilities
- Transfer and transportation

Recognition of Illness/Injury in Children and Young People

75. Critical illness or injury is relatively rare in children and young people. Early recognition of problems will lead to prompt and appropriate treatment. Currently there is no common approach to the assessment of children and young people attending emergency care sites.

76. To attain equality of care across Scotland for children and young people presenting for emergency care, there should be a common and easily used assessment tool. It is recommended that an assessment tool be developed for children and young people which can recognise:

- The severity of illness or injury
- The degree of pain and distress
- The potential vulnerability

77. This assessment method should be rapid, reliable and reproducible and we have referred to this as the 3R Tool for ease of reference.

78. This recommendation has been discussed and agreed with the children's services group of NHS Quality Improvement Scotland. As a result the development of this tool formed part of the children's services work plan scoping report published in July 2004.

National Guidelines and Standards

79. Children and young people can present with a variety of acute and potentially life threatening conditions in an emergency care setting. Currently there are few national guidelines and standards for managing these conditions. While most units will have guidance for the management of emergency conditions, these are often based on local practice and may not be fully evidenced based.

80. In order to maximise clinical outcomes, it is important to identify optimal care processes and treatments, using evidence based practice where possible. It is important that these are developed and implemented on a national basis across Scotland to ensure that children and young people receive a consistent high quality of emergency care wherever they are seen. Annex D contains a list of these conditions prepared by the review advisory group.
81. The development of these guidelines and best practice statements is a significant task. It is important to recognise the significant ongoing work of other important bodies in this regard, including the Scottish Intercollegiate Group Network (SIGN). Undertaking this work is a very necessary part of improving the quality and delivery of emergency care for children and young people.

Clinical Care Organisation

82. It is considered good practice for all health care sites providing care for children and young people to have an identified individual responsible for the organisation of clinical care of children and young people presenting at that site. The survey questionnaires indicate that not all emergency care facilities provide this (70% of general hospitals and 9% of community hospitals/medical centres answered yes to this question).

Pain and Ongoing Care

83. Evidence from the UK and worldwide indicates that pain management is often inadequate particularly in non-verbal children and infants. The survey questionnaire responses indicate less than half (43%) of emergency care sites have written policies for recognising pain in children and young people. Only 26% of emergency care sites have a written policy for recognising pain in babies.

84. Many children and young people who present to an emergency care facility will require further treatment which may be uncomfortable or painful. Appropriate sedation or anaesthesia should be provided to minimise the distress experienced by the child or young person and their family. While general anaesthesia is the highest level, it may be appropriate to use suitable sedation techniques in some circumstances. In all cases procedures should only be carried out by staff who are appropriately trained and experienced in providing sedation or anaesthesia in children and young people.

Imaging Investigations

85. Urgent imaging investigations of children and young people can take a number of different forms, for example x-rays, CT scans and ultrasound scans. As children and young people are particularly vulnerable to the effects of cumulative radiation exposure, radiological examinations should only be performed where there is a clear clinical need. This is in accordance with the Ionising Radiation (Medical Exposures) Regulations 2000.

86. Interpretation of imaging in children and young people, especially those in the younger age groups, can be challenging. Different anatomy and pathological processes, and the possibility of underlying child abuse all add to that difficulty.

87. Quality control, as well as specialist reporting is essential and all imaging of children and young people should be reviewed and reported by a radiologist or other qualified staff in a timely manner. Practitioners should be made aware of these reports so that any mis-diagnosis due to interpretation can be rapidly remedied.

27 Under use of analgesia in very young paediatric patients with painful injuries, J Alexander, M Manno, Annals of Emergency Medicine, 2003: May: 41(5); 617-622
88. It is important that emergency care staff know where children and young people in their area can obtain emergency advanced imaging such as CT scanning out-of-hours. This is of particular importance for head injuries.

89. NHS Boards should clearly identify which sites in their area can provide advanced imaging at all times and this information should be communicated to NHS 24, primary care teams, out-of-hour services and the Scottish Ambulance Service.

90. When a child or young person requires transport to another site to obtain emergency advanced imaging, the patient should be clinically stable before transport and the onward and return transport process should be as quick and safe as possible to facilitate prompt treatment.

**Short Stay/Ambulatory Assessment Facilities**

91. Short stay/ambulatory assessment facilities should be seen as a key element of emergency service provision. They provide an opportunity for observing a child or young person over a period while determining whether to discharge, transfer or admit for further care. Such an observation period may reduce the need for hospital admission.

92. Although the provision of a short stay observation ward may only be practical in larger hospitals, alternatives can be adopted in more local facilities. For example Perth Royal Infirmary has a short stay ward for children and young people as part of their ambulatory care. This is used to observe patients while a decision is made on whether to transfer to Ninewells Hospital in Dundee.

93. Emergency care sites should provide a safe and non-threatening facility where a child or young person can be observed. During stabilisation and observation there should be on-going communication with the potential referral site. Telemedicine may be of particular support for this process, particularly in remote care sites and is an essential component of the modern emergency care service. In all cases decisions to observe and delay transfer should be discussed and agreed with senior emergency care staff at the receiving site.

**Transfer and Transportation**

94. Sometimes children and young people presenting at an emergency care site will require transportation to a higher level care facility. The key decision around transport must always be whether a child or young person is sufficiently ill and/or injured to require transport outwith their local area. This decision should be made through discussion and agreement with senior staff at the potential receiving site before any decision is made to move the child or young person.

95. Transfer of children and young people to other care facilities can cause anxiety and distress for the patient and their family/carers. These decisions should involve discussion with the child or young person and their family or carers whenever possible. Transfer support should also be provided for the family or carers including travel arrangements and advice on facilities at the transfer location.
96. Inter-site transport of an ill child or young person is a complex issue and it is recommended that each emergency care site should have a specific written procedure for the transfer of children and young people.

97. This written procedure should ensure clear pathways for the care of children and young people and should consider:
   - The criteria used to determine whether transport is the best option
   - Identification of the most appropriate emergency care site
   - Site bypass arrangements
   - Transportation methods including staff support
   - Transport time frame and communications with the transfer site
   - Patient/family/carer communications and transfer support

98. This procedure should be agreed with all emergency care partners in an area including NHS 24, primary care teams, out-of-hours services and the Scottish Ambulance Service. Where appropriate it should include bypass arrangements to ensure that children and young people are transported directly to the emergency site best suited to provide their definitive care.
6

Staff Competencies and Training
99. The framework for emergency care described in Section 3 will be underpinned by the need to have competent staff at each level of care. Competency development is created through training, practical experience, maintenance of skills and updating of skills as illustrated in Figure 2.

Figure 2: Competency Cycle

100. Emergency clinical skills of health care workers rapidly decline unless put into practice on a regular basis. This causes problems for health care professions in terms of skill development and skill retention where the numbers of acutely ill or injured children and young people are small.

101. Currently there are a number of emergency care training courses provided by different organisations. These provide training in basic and advanced life support but are limited in terms of many aspects of emergency care for children and young people. In addition the review questionnaires indicated wide variation in which emergency care staff attend which course.

102. An integrated multi-professional competency based training and education package would help address this problem. Such a training package should be recognised by the relevant professional bodies.

103. The system detailed in Table 1 describes the different competencies that staff should have to provide emergency care for children and young people. The level of competency required will depend on the level of emergency care delivered at a specific site. This should be determined through assessment of local needs and should be agreed strategically throughout each NHS Board or Region (depending on the appropriate planning level). For example a rural minor injury/illness emergency care site may need to provide a higher level of care for children and young people than a similar facility in an urban setting due to remoteness from major care centres.

104. It is also important to recognise that competency retention requires a practitioner to maintain and update his/her skills. This can be achieved through a number of different mechanisms including collaborative training, flexible interactive learning packages, interactive skills based scenarios, tele-education, e-learning, work based secondments and work shadowing.
Table 1: Multi-Professional Competencies for Emergency Care for Children and Young People

<table>
<thead>
<tr>
<th>Foundation Programme</th>
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<tbody>
<tr>
<td>• Recognition of illness, injury, pain and vulnerability</td>
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<tr>
<td>• Effective communication with children and young people</td>
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<tr>
<td>• Understanding of the rights of children and young</td>
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<tr>
<td>• Basic paediatric life support competency – including</td>
</tr>
<tr>
<td>• Simple pain relief</td>
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<td>• Basic first aid</td>
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<tr>
<td>• Preparation for transfer</td>
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<tr>
<td>• Provision of child and family centred care</td>
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<table>
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<tr>
<th>Intermediate Programme</th>
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</thead>
<tbody>
<tr>
<td>• Foundation competencies</td>
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<tr>
<td>• Diagnostic and treatment skills – e.g. treatment of</td>
</tr>
<tr>
<td>• Intravenous access</td>
</tr>
<tr>
<td>• Delivery of intravenous drugs and fluids – protocol</td>
</tr>
<tr>
<td>• Treatment driven by protocols/standard options</td>
</tr>
<tr>
<td>• Advanced airway management including intubation and</td>
</tr>
<tr>
<td>• Independent assessment and treatment</td>
</tr>
<tr>
<td>• Advanced emergency care management</td>
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<tr>
<td>• Advanced analgesia</td>
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<tr>
<th>Advanced Programme</th>
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<tbody>
<tr>
<td>• Intermediate competencies</td>
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<tr>
<td>• Advanced airway management including intubation and</td>
</tr>
<tr>
<td>• Independent assessment and treatment</td>
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<tr>
<td>• Advanced emergency care management</td>
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<tr>
<td>• Advanced analgesia</td>
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105. The programme development of this tiered multi-professional competency framework could be taken forward by an emergency care development group under the sponsorship of NHS Education for Scotland.

106. This emergency care group would be multi-professional and its objective would be the design, development and delivery of training courses on emergency care for children and young people.
Developing Roles for Health Professionals

107. Independently a number of training initiatives have been developed for some emergency care professionals. The majority of these are not focused on providing emergency care for children and young people. It is important that this need is addressed. A summary of the training initiatives is provided below:

- **Higher Paediatric Fellowships in General Practice** were established by NHS Education in Scotland in 2002. These offered opportunities for General Practitioners to increase their skills and knowledge in children and young people’s health needs. If support for this continues it will allow the development of a Practitioner with Special Interest (PwSI) in Paediatrics, enabling these GPs to develop knowledge, skills, experience and confidence in managing the problems of children, young people and their carers in the community. These GPs could also be a resource for other professionals in primary care, supporting them and linking them to specialist services. They could be particularly useful in remote and rural areas and it would be essential to support these PwSI to continuously maintain and develop their skills, knowledge and experience.

- **Emergency Nurse Practitioners (ENP)** have also developed in recent years. These emerging expanded roles enable independent assessment and treatment of patients in accordance with agreed protocols. However there are currently no ENP courses specifically related to children and young people running in Scotland. This has been identified as an educational gap which requires to be scoped for future educational provision.

- **Paramedics** are registered with the Health Professional Council and their training is accredited by a number of bodies including the Institute of Health and Care Development (IHCD). Their role is rapidly evolving to include enhanced assessment/diagnostic and treatment skills (supported where necessary by telemedicine) that can prevent unnecessary hospital admissions. In some areas of Scotland ‘Pathfinder Paramedics’ are already working in greater partnership with General Practitioners, out-of-hours services and minor injuries services as semi independent practitioners to create unique solutions to local issues. With further expected changes in health care predicted, it is likely that the role will continue to develop – in the generalist emergency care environment as well as in community based care and in highly specialised roles within multi-professional care teams.

- **Nurse Consultants** are growing in number. However, there is only one children’s nurse consultant in Scotland. This *Emergency Care Framework* offers an opportunity to expand this group in order to provide leadership and direction for Emergency Care Nursing of Children and Young People in Scotland. A direct link with the NHS Education in Scotland Nurse Consultant succession planning project will ensure that Children’s Nurses are aware of the routes into consultancy and are supported to contribute to both the Emergency Care initiative and to the wider children’s agenda.

108. These developments should be taken forward in a co-ordinated multi agency manner. It is important that these practitioners have their skills recognised and that development takes place within a co-ordinated framework. In this way appropriate skills can be deployed and utilised to optimise emergency care for children and young people.
Active Inclusion of Children and Young People
Communication

109. Children and young people need information in order to participate in their health care. Participation helps children and young people feel more in control and can help them cope better with illness and treatment.

110. Practitioners should assess the maturity of the child or young person to provide the level and detail of information appropriate to help them in decision making. In particular practitioners should understand the wide variability between chronological age and development stage in times of acute stress. It is recommended that practitioners should:
   - Assess how much the child or young person is able to understand
   - Be ready to explain and follow up any cues from the child or young person
   - Listen carefully to the child or young person and give the information in the detail they need

111. Research shows that even very young children, if properly informed, can be involved in their health care\(^{28}\). While younger children may not be able to share in all the decisions, they may have strong views on how things are done, for example how medicine is given to them, i.e. pain relief in tablet form or injection. Involving a child or young person in how they are treated can give some feeling of control. This can increase confidence and help in the treatment and recovery process.

112. Sometimes difficulties may arise between respect for the wishes of parents and the rights of the child or young person to have information and be involved in decision making. Staff need to work individually with each child or young person and their family or carers and the rights of the child or young person must be considered.

113. Scotland is a diverse nation and our society is enriched by a wide variety of different cultures. It is important that cultural diversity is respected and emergency care staff should take appropriate steps to adhere to the wishes of children and young people and their families or carers wherever possible.

114. It is important to recognise that a substantial number of children, young people and their families will not have English as their first language. This must be taken into consideration during clinical care and when providing written information.

\(^{28}\) Health services for children and young people; A guide for commissioners and providers, Action for Sick Children, 2004
The Rights of Children and Young People

115. It is very important that health care practitioners understand the rights of children and young people which are governed by various statutes and guidance. While it is not the intention of this report to provide legal advice, health care practitioners should be aware of the following legislation and guidance in terms of the ability of children and young people to consent to and refuse to consent to treatment:

The Age of Legal Capacity (Scotland) Act 1991

Section 2. (4) A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

116. The following Act is also important in terms of the right of a child to refuse examination or treatment.

The Children (Scotland) Act 1995

Section 90. Nothing in this Part of this Act shall prejudice any capacity of a child enjoyed by virtue of section 2(4) of the [1991 c. 50.] Age of Legal Capacity (Scotland) Act 1991 (capacity of child with sufficient understanding to consent to surgical, medical or dental procedure or treatment); and without prejudice to that generality where a condition contained, by virtue of –

(a) section 66(4)(a), section 67(2) or section 69(9)(a) of this Act, in a warrant; or

(b) section 70(5)(a) of this Act, in a supervision requirement, requires a child to submit to any examination or treatment but the child has the capacity mentioned in the said section 2(4), the examination or treatment shall only be carried out if the child consents.

117. These areas are also reinforced by the:


Article 12 (para 1)

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
Annexes
# Emergency Care Review Advisory Group

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Tom Beattie (Chair)</td>
<td>Paediatric A&amp;E Consultant</td>
<td>Royal Hospital for Sick Children, Edinburgh</td>
</tr>
<tr>
<td>Dr Jack Beattie</td>
<td>Consultant Paediatrician</td>
<td>Royal College of Paediatrics and Child Health (RCPCH)</td>
</tr>
<tr>
<td>Mary Boyle</td>
<td>Programme Director</td>
<td>NHS Education for Scotland (NES), Edinburgh</td>
</tr>
<tr>
<td>Dr Niall Campbell</td>
<td>General Practitioner</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>Dr Charles Clark</td>
<td>Child Health Commissioner</td>
<td>Lanarkshire NHS Board</td>
</tr>
<tr>
<td>Robert Colburn</td>
<td>General Manager</td>
<td>Scottish Ambulance Service</td>
</tr>
<tr>
<td>Fiona Dagge-Bell</td>
<td>Senior Midwife</td>
<td>NHS Quality Improvement Scotland (QIS), Edinburgh</td>
</tr>
<tr>
<td>Dr Jim Ferguson</td>
<td>A&amp;E Consultant</td>
<td>Aberdeen Royal Infirmary</td>
</tr>
<tr>
<td>Dr Jamie Houston</td>
<td>Consultant Paediatrician</td>
<td>Lorn &amp; Islands Hospital, Oban</td>
</tr>
<tr>
<td>William Mason</td>
<td>Continuous Improvement Co-ordinator</td>
<td>Scottish Ambulance Service</td>
</tr>
<tr>
<td>Mary McAuley</td>
<td>Paediatric Cardiac Services, Yorkhill</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Eunice Muir</td>
<td>Director of Nursing</td>
<td>NHS 24</td>
</tr>
<tr>
<td>Dr Noelle Murphy</td>
<td>A&amp;E Consultant</td>
<td>Highlands Acute Hospitals Trust</td>
</tr>
<tr>
<td>Professor Gillian Needham</td>
<td>Postgraduate Dean (North Region)</td>
<td>NHS Education for Scotland (NES), Aberdeen</td>
</tr>
<tr>
<td>Dr Rebecca Strachan</td>
<td>Service Development Advisor (Scotland)</td>
<td>Action for Sick Children</td>
</tr>
<tr>
<td>Jean Wilson</td>
<td>Paediatric A&amp;E Nurse</td>
<td>Royal Hospital for Sick Children, Yorkhill, Glasgow</td>
</tr>
<tr>
<td>Dr Michael Wilson</td>
<td>General Practitioner</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>Fiona Page</td>
<td>Project Manager</td>
<td>SEHD Child &amp; Maternal Health Unit</td>
</tr>
<tr>
<td>Robert Stevenson</td>
<td>CYPHSG Co-ordinator</td>
<td>SEHD Child &amp; Maternal Health Unit</td>
</tr>
<tr>
<td>Dr Linda De Caestecker</td>
<td>Head of Unit</td>
<td>SEHD Child &amp; Maternal Health Unit</td>
</tr>
<tr>
<td>Dr Mini Mishra</td>
<td>Senior Medical Officer</td>
<td>SEHD Primary Care</td>
</tr>
<tr>
<td>Dr Ian Bashford</td>
<td>Senior Medical Officer</td>
<td>SEHD Chief Medical Officer Staff</td>
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### Levels of Emergency Care for Children and Young People

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Emergency Care Site</th>
<th>Lead Carer for Emergency Care</th>
<th>Support Carer for Emergency Care</th>
<th>Emergency Care Delivered</th>
</tr>
</thead>
</table>
| 4             | Specialist Children's Hospital | - Consultant in Paediatric Emergency Medicine | - Paediatrician  
- Doctor (Specialist Registrar, Senior House Officer)  
- Registered Nurse (Children)  
- Paramedics  
- Nurse Consultants (Children)  
- Emergency Nurse Practitioners (ENPs Children) | - Recognition of child protection issues  
- In-house support for child protection issues  
- Advanced life support  
- Paediatric resuscitation area  
- Paediatric intensive care/Advanced High Dependency Care  
- Paediatric ward  
- Advanced assessment and monitoring  
- Analgesia  
- Anaesthesia – paediatric expertise  
- Advanced wound care  
- Surgery  
- CT, x-ray, lab support  
- Ability to link with other care facilities for the provision of advice via telecommunications |
| 3             | General Hospital with In-Patient Paediatric Unit | - A&E Consultant with Additional Paediatric Experience  
- Liaison Paediatrician | - Doctor (Specialist Registrar, Senior House Officer)  
- Registered Nurse (Child)  
- Registered Nurse (Adult) – with paediatric skills including basic paediatric life support & child protection  
- Paramedics | - Recognition of child protection issues  
- In-house support for child protection issues  
- Advanced life support  
- Paediatric resuscitation area  
- Paediatric ward  
- Paediatric high dependency unit possible  
- Adult intensive care  
- Advanced assessment and monitoring  
- Analgesia  
- Anaesthesia – paediatric expertise  
- Advanced wound care  
- Surgery  
- CT, x-ray, lab support, telecommunication facilities |
<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Lead Carer for Emergency Care</th>
<th>Support Carer for Emergency Care</th>
<th>Emergency Care Site</th>
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<tbody>
<tr>
<td>2</td>
<td>A&amp;E Consultant with Standard Paediatric Experience</td>
<td>Liaison Paediatric Doctor (Specialist Registrar, Senior House Officer)</td>
<td>General Hospital with Accident &amp; Emergency Department without In-Patient Paediatric Unit</td>
</tr>
<tr>
<td></td>
<td>Registered Nurse (Child)</td>
<td>Registered Nurse (Adult) – with paediatric skills including basic paediatric life support &amp; child protection</td>
<td>Registered Nurse (Adult) with paediatric skills supported by on call GP</td>
</tr>
<tr>
<td></td>
<td>Registered Nurse (Child) or Registered Nurse (Adult) with paediatric skills</td>
<td>Emergency Nurse Practitioner with paediatric skills</td>
<td>Emergency Nurse Practitioner with paediatric skills</td>
</tr>
<tr>
<td>1</td>
<td>GP</td>
<td>Registered Nurse (Child)</td>
<td>Community Hospital, Minor Injury Facility, Primary Care Medical Centre, Out-of-Hours Centre</td>
</tr>
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<td></td>
<td></td>
<td>Registered Nurse (Adult) – with paediatric skills</td>
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<td></td>
<td>Basic wound care</td>
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<td></td>
<td></td>
<td>Antibiotics, tetanus, other innoculations</td>
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Services Delivered:
- Recognition of child protection issues
- Basic paediatric life support
- Basic assessment and monitoring
- Analgesia
- Basic wound care
- Antibiotics, tetanus, other innoculations
- Ability to link with expert advice locally, regionally and nationally via telemedicine
### Organisation of Emergency Care

<table>
<thead>
<tr>
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<tr>
<td>Regional Planning Groups and NHS Boards should identify the level of care that should be provided at each of their emergency care sites in accordance with the proposed <em>Emergency Care Framework</em>.</td>
<td>All Regional Planning Groups (RPGs) and NHS Boards review emergency care provision within their area to assess if services meet the level of provision contained in the <em>Emergency Care Framework</em> in Annex B. Emergency Care Forums be established at a Regional level to ensure the implementation of the <em>Emergency Care Framework</em>.</td>
<td>RPGs/NHS Boards</td>
<td>2006-2007</td>
</tr>
<tr>
<td>Sites providing emergency care for children and young people should have a named individual responsible for the overall organisation of clinical care for children and young people presenting at the site.</td>
<td>NHS Boards should ensure that all sites in their area have a lead person identified who will take responsibility for the overall organisation of clinical care for children and young people who present at the site.</td>
<td>NHS Boards</td>
<td>2006-2007</td>
</tr>
<tr>
<td>NHS Boards should clearly identify which sites in their area will at all times provide emergency advanced imaging facilities for children and young people. This information should be shared with NHS 24, primary care teams, out-of-hours services and the Scottish Ambulance Service.</td>
<td>NHS Boards, RPGs should review the current level of service provision including specialist children’s radiology services, adult services with a children’s component and services in remote and rural. NHS Boards should clearly identify which sites in their area will at all times provide emergency advanced imaging facilities for children and young people. This information should be shared with NHS 24, primary care teams, out-of-hours services and the Scottish Ambulance Service.</td>
<td>RPGs/NHS Boards</td>
<td>2007</td>
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## Emergency Care Framework for Children and Young People in Scotland – Action Plan (cont’d)

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<td>All emergency care sites should have a written procedure in place for the safe transfer of children and young people.</td>
<td>RPGs and NHS Boards should ensure that there are written procedures in place that identify when children and young people should be transferred. The procedure should include details of the arrangements and contact details of the key services involved.</td>
<td>RPGs/NHS Boards</td>
<td>2007</td>
</tr>
<tr>
<td>All emergency care sites should provide a safe and non-threatening environment for the treatment of children and young people.</td>
<td>That NHS Boards review the environments where emergency care is provided and ensure it meets the standards contained in the National Services Framework Standard for Hospital Care and that safe and non-threatening environments are provided in primary care settings and smaller hospital environments.</td>
<td>NHS Boards</td>
<td>2006-2009</td>
</tr>
<tr>
<td>All emergency care sites for children and young people should have age specific equipment appropriate to the level of emergency care provided.</td>
<td>National guidance be produced on age specific equipment for the provision of emergency care to children and young people. NHS Boards conduct an audit of provision of equipment based on the national guidance produced.</td>
<td>Quality Improvement Scotland, NHS Boards</td>
<td>2007-2008, 2008</td>
</tr>
<tr>
<td>Young people with chronic health care needs require clear arrangements for emergency care during the transition phase to adult care.</td>
<td>Care plans be produced for children and young people with chronic conditions that includes specific reference to how acute episodes requiring attendance at emergency care sites or direct admission to hospital is managed. This should also include specific information on how transition issues are managed.</td>
<td>RPGs/NHS Boards</td>
<td>2008</td>
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### Emergency Care Framework for Children and Young People in Scotland – Action Plan (contd)

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<td>All staff at emergency care sites where children and young people are seen must be</td>
<td>NHS Boards should ensure that the national recommendations on child protection have been fully implemented at Emergency</td>
<td>NHS Boards</td>
<td>2006-2007</td>
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<td>trained in child protection.</td>
<td>Care sites.</td>
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<td>written guidelines on how to manage child protection issues.</td>
<td>Care sites.</td>
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<tr>
<td>When a child or young person presents at an emergency care site with potential/actual</td>
<td>NHS Boards should ensure that arrangements are in place so that children and young people who present at emergency</td>
<td>NHS Boards</td>
<td>2007</td>
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<tr>
<td>self-harm, there should be an integrated care pathway for onward care.</td>
<td>care sites have access to an integrated care pathway for onward care.</td>
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<tr>
<td>Emergency care contacts by children and young people should be documented and</td>
<td>NHS Boards should ensure that emergency contacts are documented and forwarded to the primary care team.</td>
<td>NHS Boards</td>
<td>2007</td>
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<td>notified to their primary care team.</td>
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<tr>
<td>All emergency care sites should have a guideline for securing the ongoing health care</td>
<td>NHS Boards should ensure that guidelines are in place that secure the ongoing health care of children and young people</td>
<td>NHS Boards</td>
<td>2007</td>
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<td>of children and young people not registered with a primary care team.</td>
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## Clinical Care of Children and Young People

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<td>All emergency care sites must be able to identify recurring attendance by children and young people.</td>
<td>NHS Boards should establish information systems in all emergency care sites that allow for the identification of repeat attendances by children and young people.</td>
<td>NHS Boards</td>
<td>2007</td>
</tr>
<tr>
<td>A standard assessment method should be developed for use with children and young people at all emergency care facilities. This assessment method should recognise the severity of illness or injury, the degree of pain and distress and the potential vulnerability of the child or young person.</td>
<td>A standard assessment method be developed by NHS Quality Improvement Scotland (NHS QIS). &lt;br&gt; NHS Boards would have to ensure staff are fully trained to deliver the standard assessment tool.</td>
<td>NHS QIS</td>
<td>2007</td>
</tr>
<tr>
<td>National guidelines and best practice statements should be developed for the management of common acute and potentially life threatening conditions for children and young people.</td>
<td>National guidelines and best practice statements be developed by NHS QIS covering the management of common acute and life threatening conditions for children and young people.</td>
<td>NHS QIS</td>
<td>2006-2009</td>
</tr>
<tr>
<td>All emergency care sites wishing to sedate a child or young person should comply with the revised SIGN Guideline 58 and NHS Quality Improvement Scotland anaesthesia standards.</td>
<td>NHS Boards in their area should ensure compliance with these guidelines and standards.</td>
<td>NHS Boards</td>
<td>2008</td>
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<td>Clinical Care of Children and Young People</td>
<td><strong>All imaging interpretations of children and young people should be reviewed by an appropriately qualified professional and referred to a consultant radiologist using telemedicine where appropriate.</strong></td>
<td>RPGs/NHS Boards</td>
<td>2007</td>
</tr>
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<td></td>
<td>Develop an action plan that ensures access to support and age specific advice on radiological investigations 24/7 and recognises the role of consultant and existing practitioner roles.</td>
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<tr>
<td>Education, Training and Development</td>
<td><strong>A multi-professional emergency care competency system should be developed by NHS Education for Scotland for practitioners who provide emergency care for children and young people. Once developed competencies should be maintained and updated.</strong></td>
<td>NES</td>
<td>2006</td>
</tr>
<tr>
<td></td>
<td>A multi-professional emergency care core competency system should be developed by NHS Education for Scotland (NES) for practitioners who provide emergency care for children and young people. Once developed competencies should be maintained and updated.</td>
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<td><strong>NHS Boards should assess the competency levels of their emergency care staff to ensure their workforce competencies are appropriate to the level of care provided.</strong></td>
<td>NHS Boards</td>
<td>2007</td>
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<td><strong>Education, Training and Development</strong></td>
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<tr>
<td>The development of expanded roles for emergency care practitioners should consider the needs of children and young people and be undertaken under the guidance of NHS Education for Scotland and the relevant professional bodies.</td>
<td>NHS Education Scotland should develop this approach as part of the role out of the emergency core skills and competencies programme.</td>
<td>NES</td>
<td>2007-2009</td>
</tr>
<tr>
<td>All emergency care practitioners should communicate clearly with children and young people and actively involve them in their care and treatment.</td>
<td>NHS Boards should ensure that all staff involved in providing care to children and young people have the necessary skills and competencies to communicate with children, young people and their carers.</td>
<td>NHS Boards</td>
<td>2007-2009</td>
</tr>
<tr>
<td>Emergency care practitioners must understand the legal rights of children and young people and how these rights relate to clinical care.</td>
<td>NHS Boards should ensure that all staff are fully aware of the legal rights of children.</td>
<td>NHS Boards</td>
<td>2007-2009</td>
</tr>
<tr>
<td>Staff providing care in emergency care sites should have access to support and advice from a registered children’s practitioner on a 24/7 basis.</td>
<td>All NHS Boards and Regional Planning Groups should ensure that all emergency care sites in their area have access to professional support and advice from a registered children and young people’s health care professional.</td>
<td>NHS Boards RPGs</td>
<td>2009</td>
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</table>
Annex D

Acutely Ill and Potentially Life-Threatening Conditions for Children and Young People

**Trauma**
- Head injury – needs national policy (revisit SIGN\(^{29}\) guideline – NICE\(^{30}\) has reported different approach)
- Thoraco-abdominal trauma – needs national approach
- Burns/thermal injury – needs national approach
- Complicated orthopaedic injury – needs national approach
- Complicated wound care – needs national approach

**Sedation/Analgesia**
- Sedation – Safe sedation of children undergoing diagnostic and therapeutic procedures: SIGN guideline No 58: April 2004
- Analgesia – needs national policy, especially for acute situations

**Respiratory**
- Asthma – SIGN/BTS (British Thoracic Society) updates are placed on websites www.brit-thoracic.org.uk and www.sign.ac.uk
- Bronchiolitis – needs national policy, SIGN guideline underway
- Croup – needs national policy
- Respiratory distress – needs national policy
- Community Acquired Pneumonia in Childhood– needs national policy

**Neurological**
- Seizure – Diagnosis and management of epilepsies in children and young people: SIGN guideline 81: March 2005
- Coma – needs national policy

**Gastrointestinal**
- Diarrhoea/vomiting – needs national policy

**Allergy**
- Anaphylaxis/allergy – needs national policy

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\(^{29}\) Scottish Intercollegiate Guidelines Network (SIGN)
\(^{30}\) National Institute for Clinical Excellence
Fever

- Fever of unknown aetiology:
  - Under 3 months of age – requires special consideration
  - 3 months – 36 months of age – needs national policy
- Common pyrexial diseases for Primary Care require guidance:
  - Tonsillitis
  - Urinary Tract Infection

Endocrine

- Hypoglycaemia – Diabetic, inborn error detection, others

Cardiac Arrest

- Ensure international guidance taught and implemented – cardiac arrest, near drowning, trauma and electrocution – ILCOR/Resuscitation Council UK guidance
- Role of EPLS/PLS/APLS31 to be clarified. An Educational Framework is being developed by NHS Education for Scotland and will be rolled out as part of the implementation of this framework.
- Sudden Infant Death Syndrome – in particular in relation to RCPCH/RC pathology guidance

Surgical emergencies

- Acute abdomen:
  - Pyloric stenosis
  - Intussusception
  - Volvulus
  - Appendicitis
  - Osteomyelitis/orthopaedic infection
  - Groin swellings

Poisoning

- Need national policy to involve National Poisons Unit to ensure adequate paediatric advice and management

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31 EPLS – Emergency Paediatric Life Support
PLS – Paediatric Life Support
APLS – Advanced Paediatric Life Support