Royal College of Nursing

NURSING PRACTICE ACADEMY

Defining Staffing Levels for Children and Young People's Services

RCN UK standards

NURSING PRACTICE ACADEMY

Acknowledgements

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- RCN Children and Young People's Specialist Care Forum steering committee
- RCN Children and Young People's Continuing and Community Care Forum steering committee
- RCN Children and Young People's Staying Healthy Forum steering committee
- RCN Children and Young People's Professional Issues Forum steering committee.
- RCN UK Staffing for Safe and Effective Care Board

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Throughout this document, the term 'children and young people' is used to refer to babies (neonates), children, and young people up to the age of 18, or to the point at which an individual's transition to adult health care is completed.

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1. Executive summary

Across all four United Kingdom (UK) countries the political and policy backdrop for public sector services is increasingly marked by uncertainty and complexity. Unsustainable pressure, disparity and inequity in devolved health and social care is noted within the UK's four countries (Nuffield Trust, 2017), along with the COVID-19 impact on the health and wellbeing of all health professionals across the UK throughout 2020 and beyond (RCN, 2021b).

The Royal College of Nursing reported that this situation may impact negatively on health care provision for children and young people in the UK (RCN, 2024b). Children and young people (CYP) have a right to be cared for in age-appropriate facilities and by nurses who have the right education, training, knowledge and skills to meet their needs. This cannot be achieved without adequate staffing levels being provided for clinical care (RCN, 2024b).

Several public inquiries have highlighted key issues related to the impact of inadequate nurse staffing levels or an inappropriate mix of skills. The Francis Inquiry highlighted the need for staffing levels to be appropriate and for all staff to be properly educated, trained and regulated to meet the needs of patients (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). The Health and Social Care Act 2012 aimed to reform Health and Social Care services in England and the impact of the reforms were reviewed by the National Audit Office (NAO, 2016). The NAO (2016) reported that in relation to the NHS, a more efficient system could be employed for resourcing staffing and for training of NHS staff. This would help to minimise the risk of staff shortages and the negative impact that staff shortages have on the quality of patient care. The current **Thirlwall Inquiry** is related to the CYP setting and particularly babies.

The RCN have repeatedly called for and continue to call for improved staffing levels across all service areas. The RCN (2019d) response to the NHS England and NHS Improvement publication on Implementing The NHS Long Term Plan (NHS England, 2019a) commented on the current fragmented system where there is a lack of clarity in services. The Secretary of State for Health and Social Care currently has a broad, existing duty to promote a comprehensive health service. However, there is no specific legal duty to ensure that there is sufficient workforce to meet the needs of the population within health and care services, including taking appropriate action on supply, recruitment, retention and remuneration. particularly in England and Northern Ireland. In Scotland, the Health and Care (Staffing) (Scotland) Act 2019 (2024) details requirements for safe staffing across all health and care services with the guiding principles contained in Getting it right for every child (GIRFEC) aligning to the Act. In Wales, the Health Staffing Levels (Wales) Act (2016 and 2021) sets minimum essential staffing requirements for providers of services.

The Safe and Effective Legislation in Northern Ireland Bill is scheduled before the Northern Ireland Assembly in 2026, which will include babies, children and young people, to which the RCN responded during the consultation. The RCN (2019a) believe this duty must be made explicit, specific to the workforce supply and cannot be deprioritised without recourse. The intensity of workload within all services and across all settings continues to increase. This is due to a number of factors such as medical advances leading to increased life expectancy with illness, changes in primary care out-of-hours

provision and increased public expectation of services (RCN, 2024b). This has resulted in increased attendance at emergency care departments, with more children requiring short period acute in-patient stays for assessment and observation (Ward, 2025; Jones, 2018; King's Fund, 2013).

Evidence indicates that the care of many children could be managed in community settings if sufficient school nurses, health visitors and community children's nurses (CCNs) were available to provide care and support at home, nursery, school and college (Whiting, 2015; RCPH, 2025b; NHS, 2025). The lack of CCN educational courses and a consistent fully staffed resource of CCN teams across the UK is a key factor inhibiting care at home or closer to home. This particularly impacts those children with minor acute illnesses and long-term conditions, as well as those needing continuing care and end of life care support (Whiting, 2015).

The standards contained in this document apply to all areas in which babies, children and young people receive care, and across all types of services and provision commissioned by the NHS. This includes acute hospitals and community services, third sector and independent sector providers.

The standards within this guidance are the minimum essential recommended requirements for all providers of services for babies, children and young people (Health Staffing Levels (Wales) Act, 2016 & 2021; Health and Care (Staffing) (Scotland) Act 2019 (2024)).

Individual children's nurses, managers and health care providers must take responsibility to ensure safe staffing levels and skill mix (RCN, 2021). Workforce plans should be reviewed on an annual basis and more frequently in response to any known service pressures such as increased clinical acuity and seasonal activity (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

Governments, commissioners (including health boards and integrated care boards), providers, regulators and senior nurses are advised to audit against the standards within this document and to highlight deficiencies or variation to their senior management teams and the organisation's board. A full risk assessment should be undertaken and escalation to senior management or executive team level in all cases where staffing and skill mix deficiencies continue and are deemed unacceptable against the standards.

The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) chaired by Sir Robert Francis QC, reported the inadequate risk assessment of staff reduction, the unacceptable delay in addressing the issue of the shortages of skilled nursing staff, the poor leadership in relation to staffing policies and the fact that patients, families and staff complaints were not listened to or acted upon. The inquiry recommended that boards must take greater notice of nurse staffing levels and seek the view of nurse directors about the potential impact of any proposed major change, including changes to nurse staffing or facilities, which could affect the fundamental standards and quality of patient care (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Similar recommendations were made following reviews of children and young people's services found to be 'inadequate' or 'requiring improvement'.

Consistent themes included concerns regarding leadership, nurse staffing levels, incident reporting and learning from serious incidents, and the lack of a children and young people's strategy across the organisation. These themes continue to be echoed in ongoing national investigations (Thirlwall, 2024; DH, 2022).

The RCN has campaigned for safer care and staffing legislation to be introduced in each country within the UK (RCN, 2020d, 2020e; Health and Care (Staffing) (Scotland Act) 2019) and has published *RCN Nursing Workforce Standards* designed to support a safe and effective nursing workforce alongside national legislation (RCN, 2025b). Collating information on workforce planning considerations, patient acuity and workload measures are crucial to enable leaders to ensure nurse staffing is in place to meet children and young people's needs. To enable (nursing) leaders to ensure nurse staffing is in place to meet children and young people's needs, various considerations need to be made. Patient acuity and dependency, service planning considerations, any pertinent workforce programme or staffing tools, professional judgement, specific service standards, in-country legislation etc must all be considered to determine the right nurse staffing is in place.

Summary of CYP Safety Critical registered nurse: patient ratios in CYP settings

Key additional principles

- The ratios may need to be higher depending on acuity and professional judgement.
- The nursing support workforce is valued, and it is important that there are funded establishments (and actual workforce) that, where necessary, includes these roles (at the right level) to support the registered nurses. This is in addition to the ratio provided for the registered nurse.

Table 1: Registered nurse: patient ratios in CYP settings

Setting	Number	Further information
Inpatient wards - under 2 - over 2	24 hours/ day- 1:3 registered nurse: child 1:4 registered nurse: child or young person and a band 6 (or above) supernumerary registered nurse	See page 19
Specialist wards/units	1:2 (if HDU criteria) Others – 1:3	Page 21
Neonates/ PICU	ICU – 1:1 registered nurse: baby/child/young person (2:1 in certain circumstances) HDU – 1:2 registered nurse: baby/child/young person Neonatal Special care and transitional care – 1:4 registered nurse: baby All units should have a supernumerary registered nurse in charge (band 6 or above)	Page 16
Outpatient/ other	Outpatients – minimum 2 registered children's nurses at all times Assessment units and Day surgery- minimum of 2 registered children nurses available, 1 with advanced paediatric life support training	Page 23
Looked after CYP	A minimum of 1 dedicated whole time equivalent (WTE*) designated nurse looked after children for a population of 70,000 A minimum of 1 dedicated WTE named nurse for looked after children for each looked after children provider service. If the named nurse has a caseload the maximum caseload should be no more than 50* looked after children in addition to the operational, training and education aspects of the role	Page 36

2. Introduction

Children's services are becoming increasingly complex, encompassing general and specialist care provision across an age spectrum that extends from babies to adolescents and young adults, as well as across a variety of settings (RCPCH, 2020). Services are designed to meet children and young people's surgical, medical and mental health care needs (NHS England, 2017; NHS England and NHS Improvement, 2019). The nature of health care provision for children and young people has evolved over the last 10 years. This has resulted in an increase in higher acuity and complex physical and mental health nursing being delivered not only within hospital wards but a greater amount of acute, complex care and continuing care being provided in community and primary care settings. As a result, Royal College of Nursing (RCN) members have consistently raised the importance of identifying the safe minimum staffing levels and skill mix across all settings as a priority. Safe staffing was a key feature repeatedly raised at the RCN children and young people's nurse leaders' summit in December 2019, alongside:

- ensuring Nursing and Midwifery Council (NMC) education standards (NMC, 2019) are adhered to in higher education institutes so that pre-registration education programmes are fit for purpose and enable students to acquire the necessary knowledge, skills and competencies to meet children, young people and family's needs.
- access to flexible post-registration education and training for all nurses including but not limited to advanced nurse practitioners, specialist practitioner qualification for community children's nursing and specialist community and public health nursing programmes
- ensuring children and young people's rights and voice is heard in any service developments and organisational change (RCN, 2013b; Children in Scotland, 2017).

The number of young people with complex and long-term health care needs is growing and the need for adolescent and young adult services is increasingly important. Children and young people have a right to age-appropriate care and dedicated facilities designed to meet their specific needs (Children and Young People's Health Outcomes Forum, 2012; RCPH,2018,b; RCPH, 2020, Hope House, 2023; NICE, 2025; UNICEF, 2022). The importance of holistic transition of children and young people to adult services has been recognised (NCEPOD,2023; NICE 2023). Northumbria Healthcare Trust developed a toolkit to help health care providers provide developmentally appropriate health care, including transition from children's services to adult services (Northumbria Healthcare NHS Foundation Trust, 2017), this could be used concurrently with resources developed by **Together for Short Lives**, **Intensive Care Society** or **Ready Steady Go**.

The guidance and standards of these resources apply to all areas in which babies, children and young people receive care, as well as across all types of services and provision commissioned by the NHS including the acute and community, as well as within third sector and independent sector providers. Another example of transition work has been developed by WellChild **wellchild.org.uk/for-professionals/research-resources/8-principles-for-transition**. The standards are the minimum essential requirements for all providers of services for babies, children and young people to provide safe and effective care. These models are designed to work alongside the *RCN Nursing Workforce Standards* (RCN, 2025b)

Workforce plans should be reviewed on an annual basis and more frequently in response to any known service pressures such as increased clinical acuity, seasonal activity, national or global emergencies or pandemics and refugee crises, to ensure that capacity can meet the requirements of projected infant and child population in the local geographical area. There may be times during increased demand or surge within children's health care that these ratios and levels may require adoption, externally to their usual provision, to enable children be provided safe and effective care.

3. Policy and professional context of care provision

Policy initiatives and legislative changes significantly impact on how future services are organised and delivered within the UK's four countries. Reviews of how services are commissioned, organised and delivered (NHS England, 2017; NHS England and NHS Improvement, 2019), as well as key roles (for example specialist nursing roles such as community children's nurses, school nurses, safeguarding nurses and health visitors) impact on the need and demand for nursing numbers. Changes in commissioning, along with insufficient public health budgets in England have resulted in dramatic decreases in health visitors and school nurses in some areas (RCN, 2017c). In Scotland a review of the school nurses and health visitors' roles has resulted in planned increases to meet need and demand (Scottish Government, 2018c).

The RCN has campaigned for safer care and staffing legislation to be introduced in each country within the UK (RCN, 2020d, 2020e) recently publishing updated Nursing Workforce Standards designed to support a safe and effective nursing workforce alongside national legislation (RCN, 2025b). Wales was the first country to introduce legislation (Health Staffing Levels (Wales) Act, 2016), followed by Scotland (Health and Care (Staffing) (Scotland Act), 2019). The Welsh Government approved the extension of section 25B of the Nursing Staffing Levels (Wales) Act 2016 to children's wards (Welsh Government 2020). (**RCN launch latest Progress and Challenge report on Wales safe staffing laws | News | Royal College of Nursing, Nurse Staffing Levels (Wales) Act 2016 – Statutory summary report of nurse staffing level reports 2021-2024**). England and Northern Ireland are currently campaigning for nursing workforce legislation.

The National Quality Board (2016, 2018a, 2018b, 2018c), Shribman (2014), NHS Improvement (2020) and the NMC (2018) contend that NHS providers are supported to deliver the right staff, with the right skills, in the right place at the right time, with the nursing workforce the most important factor underpinning safe, effective, high- quality compassionate care in a timely, cost-effective and sustainable manner (RCN, 2025b). Significant concerns about future recruitment into nursing have however been raised regarding the removal of the bursary for students in England (RCN, 2018, 2020) and the increasing debt of nursing graduates. The broader multi-disciplinary team and inter-agency workforce strategies in the four countries therefore have important implications for the development of the nursing workforce, future multi-disciplinary skill mix, and therefore nursing staffing levels. Policy directives on integrated service provision combined with a growing emphasis and focus on care at home or closer to home also necessitate changes in how nurses are prepared for their roles and the delivery of services (RCN, 2025a; RCN Willis Commission, 2012a; NMC, 2018: NMC 2019).

Advancing scope of practice has enabled nursing staff to undertake tasks once viewed as the remit of doctors, blurring boundaries between different professional roles and enabling assistant practitioner and technician roles to develop to meet local service needs (RCN, 2012d). Establishing nursing associate roles in England (NHS, 2019) adds an additional resource and skill level to the NHS workforce but have yet to be fully encompassed in the care of children and young people.

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All registered nurses, nursing associates and midwifes are bound by *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* (NMC, 2018) to promote and protect the rights and best interests of their patients. This includes ensuring that staffing levels and skill-mix are appropriate to meet their needs. The Children's National Service Framework (England) (DH, 2003a) and the Children and Young People Scotland (2014) Act also emphasise that children and young people should receive high quality, evidence-based care that is appropriate to meet their specific needs and delivered by staff who have the right knowledge base, expertise and skills.

The Bristol Royal Infirmary inquiry report (Kennedy, 2001) clarified that children and young people should always be cared for by health care professionals who hold a recognised qualification in caring for children. Reports have continued to highlight the importance of staff having the right knowledge and skills to meet the needs of children and young people (RCN, 2024b).

Children and young people are frequent users of all types of health care more so than adults (NAO, 2016). The Royal College of Paediatrics and Child Health (RCPCH, 2018a) reinforce that the health services used by children and young people need to be purposed appropriately for age-appropriate services, delivered by suitably skilled practitioners are available in all health care settings. The current challenges across the UK for nurses working in children and young people's services are:

- children and young people admitted to hospital today are more acutely ill and require greater nursing intervention than in previous years
- shorter lengths of stay, increasing throughput and bed occupancy place greater pressure on nursing resources in some acute ward areas. Concurrently the complexity of care now being provided is resulting in alternative workforce challenges and bed occupancy rates
- whilst nursing roles are expanding to encompass many aspects of care and treatment undertaken by other professional groups, nursing numbers are not present to provide high quality care outside of specialist remits
- the provision of education and support to parents/carers to facilitate partnership in care and/or preparation for care at home is intensifying without the nursing resources to provide safe care
- marked seasonal variations rarely exist in most children's wards and departments, with bed occupancy rates being consistently high. Paediatric critical care (PCC) occupancy rates are in excess of 85% year-round (PICANET, 2024)
- currently, the recruitment of nursing students is positive for children's and young people's nursing, however, their vital supervision and support in clinical environments is required on top of the identified increased clinical care requirements and staff shortages.

The intensity of workload within all services and across all settings has increased because of medical advances and changes in primary care out-of-hours provision. This has resulted in increased attendance at emergency care departments, with more children requiring periods of assessment a observation and short stay in acute settings (RCPCH, 2017; Ruzangi J et al., 2020).

Evidence indicates that over a third of short stay admissions in infants are for minor illnesses that could have been managed in the community (Saxena et al., 2009, Ruzangi J et al., 2020), for example almost 75% of all children's asthma admissions able to be prevented with better primary care (Asthma UK, 2020), the decline in access to dental care and overall childhood vaccination rates decreasing. Community children's nursing (CCN) services have developed based on local need and are delivered in a variety of ways depending on local commissioning. Despite a growth in services, the UK Health Select Committee recommendations are that children requiring nursing should have access to a community children's nursing service, staffed by qualified children's nurses and supplemented by those in training (Whiting, 2015). However adequate services are still not able to be provided. The lack of consistent and adequate availability of CCN teams across the country is a key factor inhibiting care at home or closer to home, particularly for those children with minor acute illnesses and long-term conditions, as well as those who are dependent on technology or needing continuing care and end of life care support. Politically there is a requirement to reduce childhood poverty, health inequalities and support of young carers.

Children requiring provision for end-of-life care should receive 24-hour community children's nursing care wherever and whenever this is required. Workforce establishments and working patterns must therefore be able to meet the need for 24-hour end of life care whenever and wherever required. However, typically CCN Teams are providing this work on an ad-hoc or needs based often as a 'spot purchase' arrangements.

Due to this lack of adequate and sustainable services children die in hospital settings, rather than at home (DH, 2007; Scottish Government, 2012b; DoH, NI; 2016 Gisbon-Smith et al., 2021).

Registered learning disability nurses work with the child, families and multidisciplinary and multiagency teams to support the child and their family to meet their physical, intellectual, emotional, and social needs. Learning disability nurses work across all areas of health and social care to increase awareness and understanding of the possible impact of the child's learning disability upon their overall needs, explore different ways to communicate effectively with the child, and develop flexible approaches to best meet the individual child's needs.

The 2012 report *Strengthening the Commitment: the report of the UK modernising learning disabilities nursing review* (Scottish Govt., 2012a) highlighted areas for development. Drawing from direct input from learning disability nurses, the report identified a need for increased focus in the area of transitioning young people from children to adult services (NCEPOD, 2023). The report acknowledges the increase in numbers of children and young people with complex physical health care needs and confirms the valuable role that learning disability, children in care and safeguarding nurses play in children's services.

4. Nursing workforce standards and key principles

Health care delivery to children and young people has changed dramatically over recent years in attempt to a drive to reduce waiting times and lengthy inpatient stays, improve access, accelerate the delivery of services, and actively encourage the involvement of children and their parents in care (RCN, 2014a; RCPCH, 2017, 2018a, 2018b). For children with medical complexity, including physical and mental health, advances in technology and medical interventions have resulted in children with a life-limiting and life-threatening illness requiring both complex and routine care provision for lengthy periods of time throughout their lives (RCPCH, 2018b).

The landscape for children's services today is therefore one of uncertainty, with financial constraints meaning that staffing levels have again become a matter for debate and cause for concern. Regulation and inspection bodies highlight concerns about staffing shortages and media headlines report unsatisfactory practice (NHS Improvement, 2018). Significant investment is required to support the nursing workforce for children and young people across the myriad of sectors and services in which they interact. Young people, parents and carers now have high and realistic expectations of the care they wish to receive from nurses and other health care professionals.

The current regulatory environment includes the NMC (2018) which regulates every nurse in the UK. In England, sufficient staffing is one of the six essential standards all health care providers must meet to comply with the requirements of the Care Quality Commission (CQC) which was established in 2009. Infants, children and young people have the right to be cared for by sufficient numbers of staff with the right qualifications, skills and experience, and all staff must receive appropriate training and supervision to meet the professional standards that allow them to practice (CQC, 2025, 2011a, 2015; Shribman, 2014).

The Regulation and Quality Improvement Authority (**rqia.org.uk**) and the Health Inspectorate Wales (**hiw.org.uk**) provide similar regulatory governance of care provision in the respective countries of the UK, and in Scotland the Safer Patient Programme has a key role in making services safer for children and improving outcomes (**scottishpatientsafetyprogramme.scot.nhs.uk**).

The aim of regulation is to reduce risk to children. However, safe and sufficient staffing levels that will reduce risk in children's health services require defining. The list on page 6 outlines the minimum expected standards for the staffing of children's health services to provide safe care delivery (RCN, 2003, 2011a, 2013a).

Individual children's nurses, managers and health care providers, including Integrated Care Boards (England), health boards and commissioners, must take responsibility to ensure safe staffing levels. To assist this process children's nurses are required to keep up-to-date records, report adverse events, incidents, errors and near misses, and know the arrangements for reporting where the service falls below the standard for quality and safety (CQC, 2011b, 2015).

Nurse managers must ensure that needs analysis and risk assessments are in place to determine sufficient staffing levels, and that they are able to respond to changing ward/department circumstances to cover sickness, emergencies and vacancies using good quality data from quality and outcome streams and human resource departments (RCN, 2025b). This should include an escalation plan, and responsibility alignments. Tools for staffing, patient acuity and patient mix need to be available, evidence based and evaluated.

In circumstances where managers and team leaders identify that the safe minimum expected standards cannot be met, either temporarily or on a projected permanent basis, the issue must be risk assessed and escalated to a senior management or executive level team for further discussion and action.

Improved quality of care has been associated with higher numbers of registered nurses to patients (Aiken et al., 2008). American studies have for many years written about improved outcomes with higher registered nurse to patient ratios (Heinz, 2004; Kane, 2007; Aiken et al., 2008).

Patient death, cardiac arrest, nosocomial infections, and the development of pressure ulcers are reported to be directly related to poor nurse-to-patient ratios (Healthcare Improvement Scotland, 2018; NHS England, 2019). In children, Stratton (2005 and cited by Lacey et al.,2008) found a link between five indicators of quality care and nurse staffing: medication administration errors, central line infection, blood stream infection, intravenous infiltrates and parent/family complaints. Although there has been no similar work performed in children's areas with which to compare findings in the UK, Rafferty et al. (2007) suggest that hospitals with better nurse-to-patient ratios have better outcomes and that staffing levels in NHS hospitals have the same impact on factors affecting nurse retention and patient outcomes as have been found in the USA.

Cimiotti et al. (2014) correlated adverse outcomes in children with factors linked to staffing, with significant differences when there is not the appropriately skilled nursing resources. The level of education and experience of nursing staff has also been found to be associated with lower complications and mortality for children undergoing surgery (Hickey et al., 2016; Voepeil-Lewis et al., 2013). Research within neonatal services also reinforces findings, highlighting the need for resource allocation to be based on evidence (Callaghan et al., 2003; Corchia et al., 2016; Galiardi et al., 2016; Rogowski et al., 2013; Sherenian et al., 2013; Tubbs-Cooley & Younger, 2015; UK Neonatal Staffing Study Group, 2002). The paucity of evidence to underpin decisions concerning nurse staffing in children and young people's services has led to Sasso et al (2017) to extend the RN4CAST@IT (Sasso, et al., 2016a, 2016b) to the field of paediatrics.

Every hospital/trust will have a senior registered children's nurse whose role it is to be visible and credible in the promotion of services for infants, children and young people (RCN, 2014a, 2014b; National Quality Board, 2018a, 2018b; NHS Improvement,2018).

Each hospital or health care organisation's executive board will have a nominated director (either executive or non-executive) whose role and responsibility are to ensure that services for infants, children and young people are given due consideration at this level. They will have direct uninterrupted links with the lead children's nurse (RCN, 2011a). In addition, there should also be an executive lead for safeguarding children and young people across the organisation (RCN, 2019b).

The RCN has set the **Nursing Workforce Standards** which include

- Responsibility and accountability
- Clinical leadership and safety
- Health, safety and wellbeing.

These have been mapped below for CYP settings:

Table 2: Core standards relevant for health care of babies, children and young people

Aligned RCN Nursing Workforce Standards	Core standards to be applied in services providing health care for infants, children and young people
Standard 6	1. The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. See the RCN's resources on supervisory ward sister/charge nurse/team leader at **rcn.org.uk/wales/Get-Involved/Safe-and-Effective-Care**
Standard 2	2. Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff.
Standard 7 and 10	3. At least one nurse per shift in each clinical area (ward/department) will be trained in Advanced Paediatric Life Support APLS/ European Paediatric Advanced Life Support (EPALS) depending on the service need.
Standard 10	4. There will be a minimum of 70:30 per cent registered nurses to nursing support worker roles (registered nurse associates/clinical support workers/ health care assistants/student nurse associates). The precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children's intensive care, specialist, and in many cases general children's units).
Standard 8	5. A 27% increase to the minimum establishment is required to cover annual leave, sickness, study leave, parental leave and other leave. This does not include education required in specialist services
Standard 2	6. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas (this includes break times). These nurses should have completed their supernumerary preceptorship period. There may be circumstances where this cannot be met and escalation should be sort and documented. A nurse with comprehensive demonstrable education and experience in caring for children and young people, as risk assessed by a CYP registered nursing manager and designated as meeting the requirements to meet safe staffing guidance may be utilised.
Standard 7 and 10	7. Nurses working with children and young people should be trained in children's nursing (pre- or post-registration) with additional training for specialist services or roles.

Standard 7 and 10	8. 80% of registered nurses in the unit/ward should have the specific training required for the speciality, for example, children's intensive care, children's oncology, children's neurosurgery.
Standard 2 section g	9. Nursing support worker roles (listed above) and support roles (eg admin, catering and housekeeping) should be used to ensure that registered nurses are used effectively and not to substitute the registered nurse.
Standard 7 and 10	10. Nursing support workers must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks.
Standard 2 section h	11. The number of students on a shift should not exceed university, and individual clinical areas, agreed numbers.
Standard 2 section d and e	12. Patient dependency scoring should be used to provide an evidence base for adjustments in staffing levels, that should be assessed at a minimum every 24 hrs, but more frequently as required.
Standard 2 section c	13. Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels, including the level of nursing.
Standard 5, 7 and 10	14. Where services are provided to children, there should be access to a senior children's nurse for advice at all times throughout the 24-hour period. A senior qualified children's nurse is a nurse that holds a children's nursing qualification, also has a master's degree in an appropriate health/social care related subject, with a minimum of five years' full-time experience in uninterrupted clinical practice. The expectation is that this post would be at a minimum of Band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater (RCN, 2024a). All post holders of matron positions in children's services must hold children's nursing qualification.
Standard 7 and 10	15. All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (RCPH, 2019). All staff must always be able to access a named or designated safeguarding professional for advice 24 hours a day.
Standard 2	16. Children, young people and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs.

5. Neonatal services

The nurse staffing levels required for neonatal services were clearly defined in the Neonatal toolkit published by the Department of Health (England) (2009), updated by the British Association of Perinatal Medicine in 2022 (BAPM, 2022) and have since been reinforced during the recent reviews of maternity and neonatal services in England (NHS England, 2022; EFCNI, 2018) and Scotland (Scottish Government, 2017). This defines three levels of care and the associated registered nurse: baby ratios required for each level:

Table 3: Neonatal services – required nursing staffing levels

Special care and transitional care	1:4 registered nurse: baby (this group will include babies requiring treatment for jaundice and premature babies requiring tube feeding)*
High dependency care	1:2 registered nurse: baby (this includes babies requiring nasal continuous positive airway pressure (CPAP) or intravenous nutrition or observation and treatment for convulsions)*
Intensive care	1:1 registered nurse: baby (this group includes babies born with congenital anomalies requiring surgery, or babies requiring respiratory and other system support due to extreme prematurity); there are times when this ratio will be increased to 2:1 registered nurses: baby, such as in neonatal extracorporeal membrane oxygenation (ECMO)*

The above are essentially the minimum requirements for safe and effective care, but when planning the establishment for each unit, consideration needs to be given to the skill mix and available education programmes, such as the post-registration neonatal courses, the foundation degree and specific neonatal life support programmes. Clear guidance is given within the toolkit as follows:

In neonatal intensive care units (NICU) and high dependency units (HDU) 80% nursing capacity should be registered nurses and in special care 70% of nursing capacity should be registered nurses. In addition, 70% of these nurses should hold a post-registration neonatal nursing qualification. Where nursing support workers are employed, such as registered nursing associates, nursery nurses or assistant practitioners, these staff should have undertaken relevant training to a minimum level of NVQ3 or foundation degree and should work under the direct supervision of a registered nurse.

Due to the high number of staff required in neonatal units, the dependency of infants will require review on a regular basis (a minimum of once per shift) to ensure effective use of staff and to maximise capacity within each unit, ensuring that each baby receives the right care from the right person with the right knowledge, skills and competence.

Workforce plans should be reviewed on an annual basis to ensure that neonatal capacity can meet the requirements of projected increases in births in the local geographical area. In Scotland there is a mandatory workload planning tool across neonatal services (see page 4).

*The British Association of Perinatal Medicine revised and updated the detail related to the levels of care – see British Association of Perinatal Medicine (2011) Categories of care **bapm.org/resources/34-categories-of-care-2011**

And BAPM Service Quality Standards (2022) **hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf**

6. Designated children's critical care - intensive care (level 3) and high dependency services (level 1 and 2)

The optimal nurse staffing levels for paediatric critical care units /paediatric/children's intensive care units (PICU/CICUs) and high dependency units have been defined and refined over the last 25 years by both RCN and the UK's Paediatric Critical Care Society (PCCS) which published its latest version of the standards in 2021 (PCCS, 2021). These have defined levels of care and related registered nursing requirements which are now widely used during workforce planning:

Table 4: Defined levels of care and related registered nursing requirements

Level 1: Basic critical care	0.5:1 registered nurse: patient (children requiring close supervision and monitoring following surgery or with single system problems, mental health issues requiring supervision, stable long-term ventilated patient).
Level 2: Intermediate critical care	0.5:1 registered nurse: patient (children requiring close supervision and monitoring following surgery or with single system problems, non-invasive ventilation).
Level 3: Advanced critical care	1:1 registered nurse: patient (this includes children requiring intubation and ventilation) 1.5:1 registered nurse: patient (this may include ventilated children on vasoactive drugs or with multiple system problems, or a stable intubated patient in a cubicle) 2:1 registered nurse: patient (this includes children requiring ECMO or advanced renal replacement therapies)

In all categories, the ratio will increase by one level if the child is nursed in a cubicle. The ratio of registered nurse to nursing support workers (defined in table 4) should not fall below 85:15 (PCCS, 2021). Where the child is nursed in a cubicle, has mental health needs requiring close supervision, or where the condition of the child deteriorates and requires intensive care a higher ratio of 1:1 registered nurse: patient will be required until the child is stabilised. There needs to be a minimum of one nurse per shift who has APLS or equivalent training (RCPCH, 2012,RCS, 2013, PICS, 2021, RCPCH, 2018; RCN, 2020a).

PCCS Standards have stated that establishments should be calculated on a minimum of 7.01 registered nurses per bed. This figure includes an additional 27% recommended for mandatory sickness, and annual leave, however, not the specialised education for their role. Specialist support roles, integral to the delivery of care, such as Education teams, Professional Nurse Advocate roles, Matrons and Ward Managers should be in addition to the calculation. Each critical care unit should have an identified critical care matron/lead nurse who has responsibility for all nursing aspects of PCC.

Each unit must have a supernumerary registered nurse, working at an advanced level as a clinical shift leader with no allocated patients, providing support, covering breaks, managing bed/flow management and any complex scenarios that may arise (**RCN, Levels of nursing | Royal College of Nursing**). There should also be a supernumerary nurse working at enhanced level (post qualification in specialty (QIS) for every 8 beds or has increased number of side rooms/infection prevention control precautions.

A minimum of 70% of registered nurses must be in possession of a post-registration paediatric critical care award (QIS). A practice/clinical educator is required to ensure the continuing education of nursing staff, working in specialist areas to maintain high standards (NMC, 2018). Each service will set local requirements for practice educator numbers, based on:

- number of students
- number of newly qualified staff
- the range of specialities and complexity of patient needs
- how mandatory, clinical skills development and specialist updating are delivered and assessed in the organisation.

Each PCC unit should have at minimum a supernumerary clinical educator working at advanced level, to deliver this work.

All nurses providing paediatric critical care to children and young people should have training in the specialty to acquire the required additional knowledge, skills and PCCS competencies (RCPCH, 2014a; PCCS 2021) and use of an early warning score to assist in the recognition of the deteriorating child (RCN, 2019a). Education and training provision against agreed national standards should be commissioned to meet local needs. Workforce planning should be undertaken to ensure nurse staffing is sufficient to meet the requirements of children requiring critical care.

Due to the high number of staff required in PICUs, the dependency of children will require review on a regular basis (a minimum of once per shift) to ensure effective use of staff and maximise capacity within each unit. Where the unit provides a transfer service, these nurses must not be factored into the bedside nursing requirements (PCCS, 2021).

7. General children's wards and departments

Optimal nurse staffing levels for general children's wards have often been based on the RCN's guidance, *Defining staffing levels for children and young people's services: RCN guidance for clinical professionals and service managers* (first edition) (RCN, 2003).

However, in more recent years both the acuity and complexity of the patient and the reduction in length of stay combined with the inception of paediatric assessment units (PAUs) and/or clinical decisions units (CDUs) indicate the need to review staffing levels at a minimum of once a year. This should be more frequent in response to any known service pressures such as increased clinical acuity and seasonal activity. The clinical complexity and acuity of children and young people admitted to hospital continues to increase, with significant numbers of children and young people being admitted in emotional distress, including self-harm needing increased nursing support and intervention (RCPCH, 2017).

The standard for a general inpatient ward should reflect the age of the child as well as acuity. Hospitals should therefore use a proven methodology to assess acuity of patient care that clearly reflects the needs of children, not adults.

The following standards provide an indicative baseline ratio of registered and nursing support workers to children and young people, considering the distinct care requirements linked to age and development. Additional nursing support workers and nursing associates (England only) may be additionally required during the day to meet the demands of the inpatient areas such as: theatre runs, ward rounds and elective admissions, as well as to provide support to family members.

Minimum standard for:

Bedside, deliverable hands-on care

Children < 2 years of age 1:3 registered nurse: child, day and night.

Children > 2 years of age 1:4 registered nurse: child, day and night.

When setting baseline establishments, the average age of patient population should be considered, as where there are high numbers of children under two years, an increased registered nurse: patient ratio is required (see section 4, core standards).

The ward staffing complement must also have a supervisory ward manager (registered nurse working at advanced level) who are not included in the above baseline bed side establishment. The following standards should be applied for all general inpatient wards as a minimum:

- one ward manager
- one ward receptionist +/- admin support for ward manager
- minimum of one health play specialist
- minimum of one nursing support worker (NAR/CSW/HCA) (will increase according to capacity and acuity)
- one housekeeper, or equivalent post
- +/- one hostess, or equivalent post.

Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care. The nursing support workforce, including nursing associates (England only), is in addition to the registered nurse ratios.

Children and young people should be cared for by staff who have the right knowledge, skills, expertise, and competence to meet their needs.

In addition to the ward sister/charge nurse, a competent, experienced registered nurse is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an enhanced level nurse to advise on clinical nursing issues relating to children across the organisation 24-hours a day (NHS England, 2016; National Quality Board, 2018a).

8. Specialist children's wards and departments

Guidance for specialist wards (such as oncology, cardiac, neurosurgery) has previously been referred to in previous RCN guidance (RCN, 2018b). The acuity and dependency of patients on specialist wards is high. The standards for specialist wards must be supported by a suitable acuity tool. It is recognised that the clinical complexity and acuity of children and young people admitted to hospital is increasing (RCPCH, 2017). In many specialist units a number of the children on the ward will meet the criteria for high dependency care (HDU). The relevant standards must be followed (for example, 1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child.

When setting baseline establishments, the average age of patient population should be considered, as where there are high numbers of children under two years, an increased registered children's nurse: patient ratio is required (see section 4, Core standards).

The ward should also reflect the structure as described for the general ward or department for other staff including a supervisory ward sister/charge nurse.

70% of nursing staff should be trained in the specialty, with a minimum of 1 nurse who has completed this additional specialist training on duty throughout the 24-hour period.

A practice educator is required to ensure the continuing education of nursing staff, working in specialist areas to maintain high standards (NMC, 2018). Each service will set local requirements for practice educator numbers, based on:

- number of students
- number of newly qualified staff
- the range of specialities and complexity of patient needs
- how mandatory, clinical skills development and specialist updating are delivered and assessed in the organisation.

9. Emergency departments, outpatient departments, assessment units, minor injury units, day care and day surgery

This chapter includes emergency and outpatient departments, assessment and minor injuries units, same day emergency care, and day care facilities. Increasing numbers of infants, children and young people are seen in these areas and discharged home or to community care.

The environment and skills of the staff must be appropriate to the needs of children. Therefore, as a minimum all staff should be trained in:

- paediatric life support – a basic life support course with yearly update (such as the paediatric intermediate life support course) will be suitable for staff in departments such as outpatients (PICS, 2021), This will have been updated and will incorporate Paediatric Early Warning Scores (PEWS), Sepsis Six protocol, for early recognition and immediate treatment for sepsis, and SBAR (Situation, Background, Assessment and Recommendation) communication system
- in emergency departments, assessment units, day surgery and medical day care facilities, at least one member of staff should be trained in advanced paediatric life support (APLS) or EPALS (European Paediatric Advanced Life Support) at all times (RCS 2013, PICS, 2021)
- safeguarding children to level 3 as defined by the intercollegiate framework (RCN, 2019b; RCPCH, 2025a)
- effective communication with children and parents,
- pain management
- recognition of the sick child (RCN, 2017a, 2019a).

Emergency departments

Dedicated children's emergency departments

All registered nurses within a separate and dedicated children's emergency department must be registered children's nurses, or a nurse with comprehensive demonstrable experience in caring for children and young people, as assessed by a CYP registered nursing manager and designated as meeting the requirements to meet safe staffing guidance.

A minimum of two such nurses on each shift must also possess recognisable post-registration trauma and emergency training, knowledge, skills and competencies (RCS, 2013; RCPCH, 2012, 2018; RCN, 2020a).

There must be at least one nurse who has had APLS or equivalent training on duty at all times (DH, 2004, 2006; RCS, 2013; PICS, 2021; RCPCH, 2012, 2018, 2025a).

Mixed adult and children's emergency departments

In district general hospital mixed emergency departments, a minimum of two registered children's nurses with trauma experience must be available at all times (RCPCH, 2012, RCPCH, 2018; RCN, 2020a), or a nurse with comprehensive demonstrable education and experience in caring for children and young people, as risk assessed by a CYP registered nursing manager and designated as meeting the requirements to meet safe staffing guidance may be utilised. There needs to be a minimum of one nurse per shift who has APLS or equivalent training (RCS, 2013; PICS, 2015; RCPCH, 2012, 2018; RCN, 2020a).

In the current health care environment and workforce recruitment and retention challenges, interim solutions until the above standards can be met may need to be made. Increasing the knowledge and skills of nurses working in emergency or urgent care settings (RCN, 2020a) by, as a minimum, ensuring all other registered nurses caring for children in mixed adult and children's emergency departments must attain and maintain the knowledge, skills and competence for children and young people as outlined in the RCN National Curriculum and competence framework – Emergency Nursing (level 1 and 2) (RCN, 2017, 2020a, currently under review, due to be published early 2026).

Risk assessments must be completed, and deficits in care escalated through the organisations' Adverse Event Risk Reporting systems, for example, Datix, when the required standards are not met.

Assessment units

Assessment units play an increasing part of everyday care within hospitals. Due to the increasing numbers of children attending emergency departments and the overall length of hospital stay for children decreasing, many children are an inpatient for less than 24 hours (DH, 2006/7, RCPCH, 2017).

Staff with the right knowledge, skills and competences must be available to meet the needs of the children and young people attending assessment units irrespective of the model of provision. There should be a named senior children's nurse responsible for the management and co-ordination of the service (RCPCH, 2017). As with other in-patient

services, there must be a minimum of two registered children's nurses available throughout the opening hours. A minimum of one nurse must possess valid EPALS/ APLS skills at all times (RCPCH, 2017). Where nurse-led services are provided, these should include a minimum of one advanced children's nurse practitioner throughout opening hours.

Risk assessments must be completed, and deficits in care escalated through the organisations' Adverse Event Risk Reporting systems, for example, Datix, when the required standards are not met.

Minor injury units

Children requiring assessment and treatment at a minor injuries unit may present with a variety of illness and injury such as mild pyrexial illnesses, lacerations, minor gastrointestinal disturbances or respiratory illnesses etc. As a minimum, all children must be assessed by a registered nurse with the appropriate knowledge, skills and competencies (ideally a registered children's nurse). All nurses who are not registered children's nurses must have the knowledge, skills and competence outlined in the section on page 25. Risk assessments must be completed, and deficits in care escalated through the organisations' Adverse Event Risk Reporting systems, for example, Datix, when the required standards are not met.

Outpatient departments

In order to provide a high-quality appropriate service for children and young people, outpatient departments must be integrated with inpatient services, ambulatory care and community care for children and young people. Requirements and recommendations include:

- outpatient clinics run by children's specialist nurses or therapists improve the quality of care provided, particularly if more effective use of telephone and e-mail communications is afforded (Dodd, 2001)
- where digital technologies are used, all staff will require training in their use.
- minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children (RCN, 2003, 2014a).
- Risk assessments must be completed, and deficits in care escalated through the organisations' Adverse Event Risk Reporting systems, for example, Datix, when the required standards are not met.

Mechanisms must be in place to ensure ready access to professional children's nursing leadership within the service.

Day care (medical)

There is considerable variation in size and configuration of day care services, which makes it essential to review skill mix requirements in relation to local need. In view of the developments in practice in this area and the increasing provision of services through day care, there is a need for further work to determine the ideal skill mix for day care services based on the range of services provided. However, nurse staffing in all services should meet the core standards and minimum knowledge and competences outlined above.

In addition, specific considerations which might affect the skill mix include:

- the degree of integration with other children's services
- the staffing model (for example, whether the service is nurse or physician led); nurse-led services should be led by advanced children's nurse practitioners to ensure an appropriate level of knowledge and skill
- use of support staff such as play specialists, clinic assistants/ health care support workers.

Day surgery

The definition of day surgery in England and Ireland requires the patient to be admitted and discharged on the same day of intended surgery (AAGBI, 2011). According to AAGBI guidelines (2011) term infants over one month of age and ex-premature infants of a higher age limit are suitable for day surgery. The following staffing requirements are recommended:

- a minimum of two registered children's nurses must be available at all times (RCN, 2011)
- at least one such nurse must hold valid APLS/EPALS skills (DH, 2004; RCS , RCS, 2013, PICS, 2015, RCN, 2020b)
- staffing levels and skill mix will depend upon case mix, acuity, workload and whether other children's services are provided within the organisation.
- support workers and health play specialists have a key role within day surgery provision (DH, 2004).

10. Operating theatres and recovery

In the operating theatre nurses with appropriate child skills and competences must be available to support surgeons and anaesthetists. Many hospitals have developed local competencies (National confidential enquiry into peri- operative deaths, 2011). As a minimum, registered nurses and operating department technicians must possess basic paediatric airway and circulatory management skills (PCCS, 2021).

At all times there should be a minimum of one registered children's nurse on duty in recovery areas. After general, epidural or spinal anaesthesia, children must be recovered in a specifically designed unit, with two registered children's nurses for children's lists to ensure one nurse per patient in the immediate post-operative period.

The environment and skills of the staff must be appropriate to the needs of children. Therefore, as a minimum all staff should be trained in:

- paediatric life support – a basic life support course with yearly update (such as the paediatric intermediate life support course) will be suitable for staff in departments such as outpatients (PCCS, 2021), This will have been updated and will incorporate Paediatric Early Warning Scores (PEWS), Sepsis Six protocol, for early recognition and immediate treatment for sepsis, and SBAR (Situation, Background, Assessment and Recommendation) communication system
- in emergency departments, assessment units, day surgery and medical day care facilities, at least one member of staff should be trained in advanced paediatric life support (APLS) or EPALS (European Paediatric Advanced Life Support) at all times (RCS 2013, PCCS, 2021)
- safeguarding children to level 3 as defined by the intercollegiate framework (RCN, 2019)
- effective communication with children and parents,
- pain management
- recognition of the sick child (RCN, 2017a, 2019a).

In addition, skills and competence are required in effective communication with children, young people and their family, as well as recognition of the sick child (RCN, 2017a, 2019a).

In the operating theatre and post anaesthetic care unit (PACU), nurses with appropriate child skills and competences must be available to support deliver care you to babies, children and young people (BCYP).

Many hospitals have developed local competencies (National confidential enquiry into peri- operative deaths, 2011). It is important to ensure that there is clear differentiation between the competences for staff caring for BCYP and those of adults. Individual health care providers can utilise paediatric competences such as those developed by the British Anaesthetic and Recovery Nurses Association.

Anaesthetic Practitioners working with BCYP must have as a minimum:

- PILS (AAGBI, 2013). For AP's working in remote sites (such as interventional radiography or scanning) advanced level life support is recommended (RCOA, 2024). For hospitals accepting children with trauma, this includes competences in the care of children with trauma (PCCS, 2019)
- understanding of airway and circulatory anatomy, physiology and management in BCYP (PCCS, 2021), including an understanding of the Difficult Airway Society paediatric guidelines (Difficult Airway Society, 2011, NICE, 2015; PCCS, 2021; RCN, 2017b)
- understanding of normal parameters, and the ability to perform an assessment of physiological observations in BCYP (RCN 2017a' RCN 2019a)
- safeguarding level 3 training (RCN, 2019; RCPCH, 2014a)
- understanding of family centred care and play techniques and communication strategies for BCYP of all stages of development (RCN 2017a, RCN 2019a).
- knowledge and skills to manage pressure areas in BCYP.

Scrub nurses working with BCYP must have as minimum:

- Paediatric Basic life support and Safeguarding level 2 training as well as the fundamental knowledge and skills to manage pressure areas and wound management in BCYP (RCN, 2019; RCPCH, 2014a)

Recovery Nurses working in the PACU must have as a minimum:

- PILS (AAGBI, 2013). For recovery nurses working in remote sites outside of the Operating Department (such as interventional radiography or scanning) advanced level life support is recommended (RCOA, 2024)
- Understanding of airway anatomy, physiology and management in BCYP (PCCS, 2021), including an understanding of the Difficult Airway Society paediatric guidelines (Difficult Airway Society, 2011)
- Understanding of the circulatory anatomy, physiology and management in BCYP including the assessment of fluid balance and management and administration of intravenous infusions in BCYP (NICE, 2015; PCCS, 2021; RCN, 2017b)
- Understanding of normal parameters, and the ability to perform an assessment of physiological observations in BCYP (RCN 2017a, 2019a)
- To be able to recognise the sick child and demonstrate an understanding of PEWS/ SPOT tools
- Ability to assess and manage pain in BCYP, post-operative nausea and vomiting in BCYP of all developmental stages
- Knowledge and skills to manage pressure areas, surgical specific care, including wound management in BCYP
- Safeguarding level 3 training (RCN, 2019b; RCPCH, 2014b)
- Understanding of family centred care and play techniques and communication strategies for BCYP of all stages of development (RCN 2017a, 2019a)
- Calculation and administration of medications by all routes and the use of associated equipment, guided by local protocols (AAGBI, 2013; RCN 2017b).

11. Community children's nursing, health visiting and school nursing (including special needs school nursing)

Community children's nursing

As highlighted in the introduction to this document, the range and complexity of care undertaken in community settings has increased over recent years as has the percentage of the 0-18-year-old population which has access to a community children's nursing service. Services continue to be planned, commissioned, and configured in a number of different ways to meet local need (RCPCH, 2018).

Over recent years community children's nursing teams have largely comprised registered children's nurses, many of whom have undertaken additional education and training such as:

- registered specialist community practitioner (SCPHN), community children's nurse, school nurse, health visitor and/or
- specialist clinical qualifications such as oncology, palliative care and renal nursing (RCN, 2014a).

Pre-registration children's nursing education has mirrored the changes in health care provision, with many (registered nurse) children programmes now preparing registered children's nurses with a foundation in the knowledge and skills to work in the community. Valuing students in the community supports community services staffing and opens the prospects for the future registered nurses career pathways in all care settings. Undergraduate education standards emphasise the need for future nurses to be able to work across settings including the community (NMC, 2019).

Future education needs to continue to build on the pre-registration foundation, with continuing professional development necessary to enable all levels of nursing to work across all health care settings and expand their knowledge and skills.

All community children's nursing teams must be led by a registered children's nurse who has a demonstrable portfolio of relevant clinical expertise and academic accreditation of knowledge, skills and competence acquisition working at advanced level. Given the range of care provided in community settings, in recent years community children's nursing teams have evolved into mixed teams with a range of practitioners from assistant practitioners to play specialists, registered nurses and therapists based on local need rather than strategic development.

Within community children's nursing teams, the minimum ratio of registered nurse to nursing support workers should not fall below 70:30%. Within this, there is a minimum requirement of 25% of the registered nurse component being CCNs who have completed a recognisable community education and development programme.

Children's continuing care teams are managed in different ways to that of 'core' community children's nursing services. Within these teams, a workforce predominantly composed of health care assistants or support workers ensure maximum efficiency in delivering care over a wide geographical area to children and families in their own homes, schools or respite care. It is often considered that children's continuing care teams are in effect a 'virtual ward'. The skill mix of registered nurses and nursing support workforce are virtually in place to cover the specific care arrangements for children and young people, with open lines of communication at all times between team members. Delegation of clinical tasks and care needs must be in line with recommended practice, clinical governance and in accordance with The NMC Code (NMC, 2018; RCN, 2024b; RCN 2020c; RCN, 2024b). These teams may have a lower minimum ratio of nursing support workers to registered nurses due to the complexity and acuity of care needed.

In 2013, the RCN recommended that for an average-sized district with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses were required to provide a holistic and comprehensive community children's nursing service in addition to any individual child specific continuing care investment (RCN, 2009a; RCN 2009b; RCN, 2013a). Specific case mix, range of service provided and available skill mix (as well as commissioning arrangements at local level) clearly requires a higher ratio to ensure safe and effective staffing (RCN, 2020c). The population of children, the complexity, safeguarding and technological dependency needs of children and young people have increased in addition to funding changes, therefore the community children's nursing workforce across each district requires review and almost certain expansion or differing models of care to meet increasing demands.

The importance of investment in CYP primary health care provision has been further identified by Lord Darzi's review, RCPCH Blueprint (2018) and SAPHNA (2023).

Notable changes to funding in England have impacted children with special needs through the significant reduction of school nursing posts and redistribution of public health priorities. The 2014 Children and Families Act extended consideration of the need for support for children with special educational needs up until 25 years which adds additional workload to effectively manage the transition of young people with special educational needs to adult services.

Overall, community children's nursing workforce establishments and working patterns must also be able to meet the need for 24-hour end of life care whenever and wherever required. Workforce and establishment reviews must be able to clearly and explicitly demonstrate this palliative and end of life care need in order to ensure the necessary nursing establishment increase.

Calculating the dependency of any patient in the community is complex; whilst children and young people often live with their families and have carers around them, it is not always possible for every family/carer to provide the care needed. The RCN has previously outlined examples of current community children's nursing services and ways to manage complexity, including the use of a caseload dependency complexity matrix and 'caseload dependency continuum' of local clinical needs – across the four domains of community children's nursing:

- acute/short term conditions
- children with long term conditions
- children with complex needs/conditions
- children with life limiting or life-threatening conditions (RCN, 2020c).

Health visiting

Health visitors are registered nurses from any of the four branches who undertake further education and training to become specialist community public health nurses (SCPHN) (NMC, 2004; RCN, 2011). These education programmes support practitioners to develop skills in child health, health promotion, public health and education, and is both university and community based with practitioners having to successfully complete both components to gain registration.

There is limited evidence to date to support an RCN position on optimum caseloads for health visitors, particularly where services are evolving in response to changes in health and social care. In his 2009 progress report on the protection of children in England, Lord Laming recommended a maximum caseload of 300 families (or 400 children) per full- time health visitor, with actual numbers being lower depending on caseload complexity and other factors (Laming, 2009). The RCN's 2011 position on health visiting in the early years and Cowley et al. (2013) review recognised that caseloads should be lower depending on the number of vulnerable families the health visitor has on the caseload, deprivation indices, geography of the patch and the team support available, including access to administrative assistance (RCN, 2011). Unite/CPHVA (2009) stated that 400 children 'must be the absolute maximum caseload size' and that the 'average and more normal caseload size should be no more than 250 children'. They also advise that caseloads for health visitors working in areas of high vulnerability should be much less. The Institute of Health Visiting (2018) recommends an average of one health visitor to 250 children to deliver comprehensive health improvement and has called for the development of an appropriate workload tool.

As the dependency of families has increased health visiting teams have developed to include different professional roles and skills, and registered children's nurses and nursery nurses are often key members of the team.

School nursing

School nurses are registered nurses who have successfully completed a post-registration graduate programme and are registered as a specialist community public health practitioner (NMC, 2004, RCN, 2012c). They work with school-aged children across a variety of settings and undertake a range of care activities from public health to clinical care tasks, especially for children and young people in special schools.

Good practice would indicate that each cohort of schools has a named school nurse responsible for co-ordinating the care across both the primary and secondary schools; and that the school nursing service should be a year-round service which incorporates team members of different grades who have a variety of skills and knowledge.

There should be a minimum of one qualified school nurse for each secondary school and its cluster of primary schools. The actual number will vary dependent upon the size and complexity of the school population, the number of vulnerable children, deprivation indices and geography of the patch. Qualified school nurses will be supported by a skill-mixed team that includes a number of registered nurses, nursery nurses and health care support workers (Henshawm, 2024).

The key skills for school nurses include:

- leading, delivering and evaluating preventative services and universal public health programmes (as set out in the Healthy Child Programme 5-19) for school-aged children and young people, within both school and community settings
- delivering evidence-based approaches and cost-effective programmes or interventions that contribute to children and young people's health and wellbeing; reduction in childhood obesity, reduction in under-18 conception rates, reduction in prevalence of chlamydia and management of mental health disorders (such as depression and conduct disorder), co-ordinating services, referring to other agencies and delegating within the team to maximise resources and utilise the expertise of other skilled professionals
- supporting a seamless transition into school, from primary to secondary school and transition into adulthood
- managing the interaction between health and education so that the child or young person enjoys good physical, mental and emotional health and wellbeing therefore achieving optimal education
- leading support for children and young people who have complex and/or additional needs including providing or co-ordinating support, education and training for families, carers and school staff
- identifying children and young people in need of early help, and where appropriate providing support to improve their life chances and prevent abuse and neglect; this includes working with children and young people at risk of becoming involved in gangs or youth violence
- contributing as part of a multi-agency team to the response for children, young people and families who have multiple problems.

Special needs school nursing

A recent study into special needs school nursing recommends a minimum of one special needs school nurse based in every school where there are children with complex fluctuating and complex long-term health needs during school hours (Williams, 2019). A useful tool to assist with the commissioning and workforce planning includes *Assessing Nursing Needs in School* (Ward, 2018). The RCN has published guidance related to meeting the health needs of children and young people in schools and community settings (RCN, 2024b).

12. Children and young people's mental health

Nursing must continuously evolve and adapt to the ever-changing needs of our diverse populations. Mental health is everyone's business, no matter your field of practice or place of work (Jones, 2023). This section explores the role of nursing in supporting the mental health of children and young people within various practice contexts.

School, health visiting and primary care

School nurses and health visitors have a key role in providing emotional health and wellbeing support to those in their care (RCN, 2017c, 2017d, 2018a, 2019c).

Child and Adolescent Mental Health Services

More specialist CAMHS (child and adolescent mental health services) are provided in inpatient and community settings, by multi-disciplinary teams including psychiatrists, psychologists and nurses.

General Hospital

When children and young people with mental health problems are admitted to general admission children's wards, their needs can be higher than those without mental health problems.

Choice and empowerment are crucial to person-centred care. In providing mental health care, nurses must be confident in offering young people a choice – providing clear information on care and treatment (Rees et al., 2022).

The RCN recommends that a mental health nurse with specialist CYP knowledge is always available to the young person to provide a comprehensive ongoing assessment of needs.

When children and young people require access to a mental health in-patient bed but are delayed in transferring, they can be cared for in a suitable children's ward with appropriate in-patient facilities and staff until a mental health in-patient bed is found.

However, immediate actions should be taken to reduce the risks to children and young people with high-risk behaviours staying in the acute paediatric ward (Health Services Safety Investigation Body (HSSIB), 2023, 2024).

13. Neurodisability and Learning Disability Services for Children and Young People

The families and carers of children and young people who have learning disabilities, autism or both should be able to expect high quality care across all health care services (NHSE, 2018) from suitably knowledgeable, skilled and competent staff (National Quality Board, 2018c). All services should be accessible to children and young people with learning disabilities, with the ability to make reasonable adjustments to meet their needs effectively. There may also be additional and complex neurodisability needs that require dedicated provision with the required skills and competencies.

Many organisations have employed registered learning disability (LD) nurses in an educational remit within inpatient and primary care and community settings. By sharing their knowledge, they empower other staff to provide higher quality care to an increasing number of CYP with learning disabilities and/or autism.

Acute hospitals may have neurodisability services that meet the complex care needs of children and young people with neurological conditions, such as cerebral palsy or profound and multiple learning disabilities. These young people may need support with PEG feeding, aspiration, epilepsy, posture management, skin integrity, constipation, communication and engagement, and mental wellbeing.

Community children's learning disability/neurodisability services are not consistently available. These services can play a vital role in supporting young people and their families in care co-ordination between paediatric services, acute care, primary care, and school health services. They can also provide invaluable advice to families on development, challenging behaviours, and health maintenance and promotion.

Some families of children and young people with neurodisabilities will have life limiting conditions. Hospice services are often nurse-led services that provide vital respite for these young people and their families. They can also support families with end-of-life care and support.

The Royal College of Nursing recommends:

1. All acute hospitals should employ a minimum of one registered learning disability nurse to educate, train and up-skill staff, and to advise on care for children and young people with learning disabilities and/or autism.
2. Each local area should review the number of children and young people with learning disability and/or autism within their CYP population (Care Quality Commission, 2020b) to ascertain the required establishment of registered learning disability nurses needed within their community services (NHSE, 2015).
3. Further research to determine national workforce modelling to provide consistency to children, young people and their families with learning disabilities.

4. Each organisation must assess the number of registered nurse learning disability nurses required, recognising that some may require a team of registered nurse learning disability nurses to provide a seven day a week service to meet the needs of the children and young people with learning disabilities and autism accessing their services.
5. All children and young people with learning disabilities and autism should have access to a registered nurse learning disability nurse.

14. Adolescent and young adult units

Young people with long-term conditions are increasingly surviving into adulthood. Increased focus is required to ensure the right expertise and support is available to young people as they transition into adult services across all health care settings.

The National Service Framework (Standard 4) states that: 'All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood' (DH, 2004a). The transition to adult services has been identified as a period of time when young people can be lost from health care, due to the failure of transition arrangements (Kennedy, 2010). The increasing survival of young people with life-limiting or long-term conditions adds additional challenges into transitioning to an appropriate adult team and further work is needed to determine the best configuration of services to manage these young people between the ages of 16 and 25 (NHS Long term plan, (2025); NHSE, 2019; NCEPOD, 2023).

Staffing requirements for adolescent services are not clearly defined, but there are core principles that should be considered when caring for adolescents and young adults:

- workforce planning should consider both the physical and psychosocial needs of adolescents, with the registered nursing workforce consisting of registered children's, adult, mental health and LD nurses who have knowledge, skills and competence in child and adolescent health (Osborn et al., 2019) and to provide care for young people to meet their individual developmentally appropriate health care needs.
- transition to a service with appropriate expertise for the individual young person.
- nurses working in this environment should receive training in adolescent health care.

15. Independent and private sector provision

Families accessing private health care for their children has grown considerably in the past decade, and more so following the COVID-19 pandemic in the UK. While standalone private hospitals, primary care, community, and acute pathways exist in the independent sector for children and young people, elective surgery day case/inpatient and outpatient pathways form most of the activity across the sector.

The principles of safer nursing staffing in the main body of this document are relevant to all independent providers, including aspects of training in resuscitation and safeguarding but there are specific aspects that independent providers should consider as a minimum requirement for safer nurse staffing with regards to leadership, In-patient/day care ward areas, post-operative recovery areas and out-patient areas.

Leadership

Health care providers of day case/inpatient facilities and or where 'invasive procedures' (as defined in the *National Safety Standards for Invasive Procedures 2* [NatSSIPs] from the Centre for Perioperative Care) are performed for children and young people, should ensure that leadership is provided by a registered nurse (Child) who holds responsibility for quality and safety which includes safe staffing in line with this document. Where providers offer services for consultation only and non-invasive procedures, a designated lead role in the management structure from the provider will be responsible for all aspects of CYP care ensuring staff have the relevant mandatory skills to care for CYP.

In-patient / day care ward areas

There are many providers in the independent sector who have designated, secure wards for their surgical services for CYP. However, there are also providers who care for CYP in designated cubicles on adult wards.

Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care. The nursing support workforce, including nursing associates (England only), is in addition to the registered nurse ratios and nursing associates should not be considered as a "second" registered nurse (Child).

In any circumstance, children (aged less than 16 years) should be cared for by registered nurses (Child) and the minimum standards outlined below should be met. Children and young people aged 16 and 17 years wishing to follow the adult pathway may be cared for by registered nurse (Adult) and a registered nurse is the provider's responsibility to ensure that registered nurses (Adult) have the necessary skills and experience to provide safe and effective care.

As a minimum:

- there must always be at least one member of nursing staff on duty in the ward area qualified in advanced paediatric life support (APLS / EPALS).
- registered nurse (child) to patient ratio in the ward should be
    - 1: 4 if the children are over two years old,
    - 1:3 if the child is under two years old both day and night
    - a contingency plan where patients exceed day case admission to ensure this ratio is achieved.
- there should always be a minimum of two children's nurses on duty for inpatient/day case care and no in patient area must ever be staffed with one registered nurse (child)
- a registered nurse (child) should always remain on the ward with any post-operative children once the first child has returned from theatre.

Post-operative recovery areas

Designated, child friendly recovery areas with essential paediatric equipment and adequately trained and experienced staff should be in place for all providers offering surgery for children on a CYP pathway.

As a minimum:

- staff (which will include operating department practitioners and registered nurse child or adult) should have appropriate children and young people skills, to support surgeons and anaesthetists and the provision of safe post-operative care in recovery areas
- immediately after anaesthesia, the child should be managed in a designated CYP recovery bay, with the required clinical equipment, staffed on a 1-to-1 basis by a registrant at least until the child can manage their own airway (ie free from airway adjuncts and opening maneuvers)
- the staff in the recovery area should have PILS, paediatric experience including how to respond in an emergency and may be an operating department assistant, RN Child, or Adult
- at least one member of staff with advanced skills and training (EPALS / APLS) in life support for children should always be available to assist where required. (While providers may choose for nursing and AHP staff to complete courses in EPALS / APLS, as minimum the hospital resident doctor may assume this role).

Out-patient areas

Non-invasive, consultation outpatient activity forms the largest proportion of activity for CYP services in the independent sector and many providers safely and adequately provide care from RN Adults with the necessary skills and experience.

Where providers are performing invasive procedures in an outpatient setting an RN Child should be employed and the minimum standards outlined below should be met:

As a minimum:

- one RN (Child) present for all invasive procedures for CYP less than 16 years old
- RN (Adult) may care for CYP where providers do not perform invasive procedures

16. Children's hospices

Children's hospices in the UK are independent and third sector organisations.

Staffing ratios are difficult to standardise within the children's hospice sector given the range of care and scope of services provided in-hospice, home and community settings by hospice organisations. The chapter on specialist wards and departments provides a useful model for in-hospice care provision and the section on community children's nursing provides a baseline for community services provided by children's hospices.

No single 'best standard' for staffing currently exists for the hospice sector. It is recommended that hospices consider/analyse the model and level of care delivered; the profile of the patient population (e.g. age; diagnosis; stage of disease) and family care delivery, alongside the needs of individual children and their families; environmental factors (e.g. distance from emergency facilities) and the availability of medical support.

Some children and young people accessing children's hospices are accompanied by carers. It is essential that there is clarity with regards to the roles and responsibilities of the child's care team and hospice staff in relation to care delivery during the child's stay.

The National Institute for Health and Care Excellence states that families of children with life- limiting conditions who are approaching their end of lives and are being cared for at home should have access to advice from a children's palliative care consultant (for example by telephone) and registered children's nurses at any time (day and night). This is critical in making sure that children with life-limiting conditions and their families can choose to receive palliative care at home (NICE, 2019).

17. Safeguarding and looked after children nurse specialists, named and designated nurses

The child protection system in the UK is the responsibility of the government of each of the UK's 4 nations. Each government is responsible for passing legislation, publishing guidance, and establishing policy frameworks. All health care organisations and health care providers have a duty outlined in legislation, to decide to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm. Across the UK, specialist safeguarding/child protection professionals provide expertise and have specific roles and responsibilities in safeguarding/protecting children. The Intercollegiate document – **Safeguarding Children and Young People: Roles and competencies for health care staff** outlines specific nurse staffing requirements which include:

- a minimum of one dedicated WTE* named nurse for safeguarding children and young people for each acute health care organisation with dedicated clinical nurse safeguarding specialists for each additional site.
- for community health care organisations, a minimum of one dedicated WTE* named nurse for safeguarding children and young people for a child population of 70,000. (*While it is expected that there will be a team approach to safeguarding children and young people the minimum WTE named nurse may need to be greater dependent upon the numbers of serious case reviews, the requirement for attendance at safeguarding committees, the requirement to provide safeguarding supervision for other practitioners, the local deprivation indices, the local child population and the number of children subject to child protection plans, the size of the organisation and whether it provides tertiary services.)
- A minimum of 0.4 WTE* named midwife for safeguarding should be available in each organisation providing maternity services.
  *The WTE will vary dependent upon, for example, the number of births, the requirement for attendance at safeguarding committees and the local deprivation indices.
- A minimum of one dedicated WTE* designated nurse for a child population of 70,000. (*While it is expected that there will be a team approach to safeguarding children and young people the minimum WTE designated nurse may need to be greater dependent upon the numbers of local safeguarding partnerships, sub committees, unitary authorities and clinical commissioning groups covered, the requirement to provide safeguarding supervision for other practitioners, as well as the geographical area covered, the number of children subject to child protection plans and local deprivation indices.) (RCN, 2019f)

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Services and responsibilities for looked after children/looked after and accommodated children are also underpinned by legislation, statutory guidance, and good practice guidance (RCN, 2020f). The Intercollegiate document – **Looked after children: Roles and competencies for health care staff** (due for combined publication with safeguarding) outlines specific nurse staffing requirements which include:

- a minimum of 1 dedicated WTE Named Nurse for looked after children for each looked after children provider service. If the Named Nurse has a caseload the maximum caseload should be no more than 50** looked after children in addition to the operational, training and education aspects of the role (**The precise caseload of looked after children held by the Named Nurse will be dependent on the complexity, geography, population and size of the catchment area served)
- a minimum of 1 dedicated WTE** Designated Nurse Looked After Children for a population of 70,000 (**While it is expected that there will be a team approach to meeting the needs of looked after children and young people the minimum WTE Designated Nurse Looked After Children may need to be greater dependent upon the number of Local Safeguarding Partnership Boards, sub group committees, unitary authorities and clinical commissioning groups covered, the requirement to provide Looked After Child supervision for other practitioners, as well as the geographical areas covered, the number of children looked after and local deprivation indices) (RCN, 2020f).

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Description

These Defining Staffing Levels for Children and Young People's Services RCN UK standards are the minimum essential requirements for all providers of services for babies, children and young people to provide safe and effective care.

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Disclaimer

Due to the limited availability of large volumes of contemporary evidence in this area, portions of the current work rely on the best information presently accessible. The RCN acknowledges these evidence gaps and is actively working to strengthen the evidence base. Additional research and supporting data will be reviewed, incorporated, and completed before the next edition.

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