Guideline

Paediatric Service Capability (Paediatric Medicine and Surgery for Children)

Summary This Guideline outlines the service capability standard for each level of Paediatric Medicine or Surgery for Children service. It explains service capability in the context of networked care and describes how to assess and report on service capability, and notify of any planned changes to a service capability level. It must be used for planning and maintaining service capability of Paediatric Medicine and Surgery for Children services.

Document type Guideline

Document number GL2024_005

Publication date 13 June 2024

Author branch Health and Social Policy

Branch contact (02) 9424 5944

Replaces GL2023_022

Review date 13 June 2029

Policy manual Not applicable

File number H24/47130

Status Active

Functional group Clinical/Patient Services - Baby and Child, Governance and Service Delivery, Medical Treatment, Nursing and Midwifery
Corporate Administration - Governance
Personnel/Workforce - Workforce planning

Applies to Ministry of Health, Local Health Districts, Specialty Network Governed Statutory Health Corporations, NSW Ambulance Service, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, NSW Ambulance Service, Private Hospitals and Day Procedure Centres

Audience All Chief Executives;Health Service Planners;Directors of Clinical Operations;Emergency Department;Paediatric Medical Leads;District Paediatric Nurse Consultants;Health Facility Managers

Secretary, NSW Health

NSW Health

Guideline

Paediatric Service Capability (Paediatric Medicine and Surgery for Children)

Guideline Summary

NSW Health is committed to delivering a networked system of Paediatric Medicine and Surgery for Children services.

This Guideline provides health service planners and service providers with a standard set of capability criteria and introduces new notification and reporting requirements. It assists NSW local health districts (districts) and specialty health networks (networks) to plan and deliver safe, high quality Paediatric Medicine and Surgery for Children services to meet population needs.

Key Principles

Service capability and networked care

Service capability describes the activity and complexity of clinical care that a service can safely provide in collaboration through formal agreements with its supporting services (allied health, pathology, child protection services, etc). Services may be delivered face-to-face or through virtual care. It is the level of care a service anticipates delivering in business-as-usual practice.

This Guideline specifies the standards for each level of service capability:

- Paediatric Medicine service capability levels are 2, 3, 4, 5 and 6
- Surgery for Children service capability levels are 2, 3, 4 and 6 (no level 5).

The 'highest' or most complex level of care is provided by Level 6 services. Risk management plans must be in place to address capability gaps when a service does not meet all criteria at a specific level.

All districts and networks are to assess and maintain the designated service capability of their Paediatric Medicine and Surgery for Children services. These services must operate within formalised networking arrangements as outlined in NSW Health Policy Directive *Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019).

Within these networking arrangements, higher level services are responsible for providing lower-level services with support, advice and management of paediatric patients. While any service can provide support for services at a lower capability level, Levels 4, 5 and 6 services have specific roles.

Accessible and culturally appropriate information about the capability level of a service must be provided to patients and their families/ carers to help them understand what can be

provided at the service and what to expect if transfer for a higher level of care or return transfer is required.

Assessment and reporting of service capability

An initial assessment of service capability is to be undertaken when establishing a new Paediatric Medicine or Surgery for Children service. Re-assessments are to be carried out:

- Whenever there is a planned change to service level.
- Regularly at the discretion of the district/ network to support safety and quality practices linked to the district/ network clinical services planning cycles.
- To fulfil NSW Ministry of Health reporting requirements.

Assessment is a collaborative exercise, with leadership from the Local Health District Paediatric Medical Lead, senior management and health service planning. It must be completed in partnership with a range of clinical representatives and may include consumers and carers. Sign off is by the district/ network Chief Executive.

The NSW Ministry of Health will request from district/ network Chief Executives a report of Paediatric Medicine and Surgery for Children service capability levels as follows:

- A comprehensive assessment including a risk management and service development plan within 6 months of the release of this Guideline.
- An update on service levels and risk management and service development plans each May/ June (a comprehensive assessment is not required at this time, but may be completed).
- An ad-hoc report at any time, as required.

Routine statewide reporting of service capability will assist the NSW Ministry of Health in statewide planning for Paediatric Medicine and Surgery for Children services.

Notification of a change in service capability

Districts and networks must have local processes in place to communicate with key partners in a timely manner any changes to a Paediatric Medicine or Surgery for Children service capability level. This includes a move to a lower or higher level of capability.

In line with the *Health Services Act 1997* (NSW) the Secretary of NSW Health must be notified in advance of any planned commencement of a new service and/or closure or restriction of the range of services offered by districts and specialty health networks. A planned move to a lower service capability level would constitute a planned restriction of service.

Implementation resources

A suite of resources to support implementation of this Guideline are available on the Paediatric Service Capability page of the NSW Health Intranet. These include assessment, reporting and notification tools.

Revision History

Version	Approved By	Amendment Notes
GL2024_005 June-2024	Deputy Secretary, Health System Strategy and Patient Experience	Minor amendments to align with the *NSW Health Guide to the Role Delineation of Clinical Services* (2024) including Level 6 Service Capability Tables: Minimum Core Services for Surgery for Children changed to 6. Adolescent area added to Resources for Level 6 Paediatric Medicine services.
GL2023_022 December-2023	Deputy Secretary, Health System Strategy and Patient Experience	Introduces new notification and reporting requirements. Includes level 6 Service Capability and more detail on scope of service capability levels. Also included in the revision and no longer current (rescinded by this document): • NSW Paediatric Service Capability Framework Companion Toolkit • Surgery for Children in Metropolitan Sydney – Strategic Framework.
GL2017_010 June-2017	Deputy Secretary, Strategy and Resources	New Guideline

Contents

1. Background

1.1. About this document

This Guideline outlines the service capability standard for each level of Paediatric Medicine or Surgery for Children service. It explains service capability in the context of networked care and describes how to assess and report on service capability, and notify of any planned changes to a service capability level. Local health districts (districts) and specialty health networks (networks) must use this Guideline in planning and maintaining the capability of their Paediatric Medicine and Surgery for Children services.

Section 7 outlines the optimum standard criteria for each service capability level in the Paediatric Medicine (Section 7.3) and Surgery for Children (Section 7.4) tables. Appendices provide supporting information on Nursing workforce (Appendix 1)[1], Patient risk (Appendix 2), Indicative list of surgery for children (Appendix 3), and Surgical complexity at each service capability level (Appendix 4).

This Guideline is a companion document to the *NSW Health Guide to the Role Delineation of Clinical Services* (2024) and NSW Health Guideline *Maternity and Neonatal Service Capability* (GL2022_002). Paediatric Medicine and Surgery for Children service capability levels are determined by applying the three documents and conducting relevant service capability and risk assessments.

A suite of resources to support implementation of this Guideline are available on the Paediatric Service Capability page of the NSW Health intranet. These include assessment, reporting and notification tools.

1.2. Scope of this document

This Guideline applies to Paediatric Medicine and Surgery for Children services provided by districts and networks. NSW private hospitals with paediatric class facilities and Australian Capital Territory (ACT) services may also find this Guideline informative as they partner with NSW Health services.

Paediatric Medicine and Surgery for Children services provide care for infants, children and adolescents up to the age of 16 years and their families/ carers. Services may also be delivered to adolescents 16 to 18 years with chronic or complex conditions or who have not completed transition to adult health services. They do not include services delivered to babies as part of the birth episode. Maternity and neonatal services are addressed in the NSW Health Guideline *Maternity and Neonatal Service Capability* (GL2022_022).

In line with the *NSW Health Guide to the Role Delineation of Clinical Services* (2024), other services for infants, children and adolescents are planned separately to Paediatric Medicine and Surgery for Children services. These include child and family health, child protection, youth health, community health, and child and youth mental health services. Paediatric

[1] Guidance is available for the nursing workforce on staffing arrangements for clinical services. The same guidance is not currently available for other professions.

Medicine and Surgery for Children services must develop formal pathways with other services for infants, children and adolescents to facilitate patient access and integrated care.

1.3. Relationship to role delineation

The *NSW Health Guide to the Role Delineation of Clinical Services* (2024) describes the minimum support services, workforce and other requirements for clinical services to be delivered safely by a facility. It is a tool primarily used by health service planners that can also inform clinical governance decisions.

This Guideline builds on role delineation and assists service and workforce planning by adding detail about the clinical scope, capability and resources, clinical governance arrangements, workforce and consultation required for a service to operate safely at each capability level.

1.4. Key definitions

Allied health professional	Allied health in NSW Health comprises 23 different professions. Examples include speech pathology, occupational therapy, physiotherapy, psychology, social work, pharmacy, dietetics and child life therapy.
Clinical Emergency Response System (CERS)	Formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/ or mental state) as stated in NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018). Includes the facility-based and specialty unit-based responses (clinical review and rapid response), as well as formalised referral and escalation steps to seek expert clinical assistance and/ or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).
Clinical Emergency Response System (CERS) Assist	NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating patient (red zone observations or additional criteria) in a public health care facility as stated in NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018).
Clinical privileges	The term ‘clinical privileges’ means the kind of clinical work (subject to any restrictions) that a public health organisation determines a practitioner is to be allowed to perform at any of its hospitals or other health services.

	While the term 'scope of clinical practice' is used in several other jurisdictions, the use of the term 'clinical privileges' remains in NSW. See NSW Health Policy Directives *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* (PD2019_056) or *NSW Health Nurse Practitioners* (PD2022_057) for further information.
Close observation service	Close observation requirements applied to a paediatric ward/ unit as needed; no designated close observation unit as for adult patients. Patient admission and medical care remains under the direction of the admitting specialist.
Credentialing	The formal process of assessing and verifying a practitioner's credentials and other relevant professional attributes for the purpose of forming a view about their competence and suitability to provide safe, appropriate health care services. See NSW Health Policy Directives *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* (PD2019_056) or *NSW Health Nurse Practitioners* (PD2022_057) for further information.
Multidisciplinary care	When professionals from a range of disciplines work together with a patient to deliver comprehensive care that addresses as many of the patient's needs as possible.
Multidisciplinary team	A team made up of at least one patient and multiple health professionals from several different disciplines, often including medical, nursing, allied health and Aboriginal health. Health professionals may also be from different clinical streams. A multidisciplinary team is first and foremost, centred upon the needs of the patient and their carers.
Neonatal services	Neonatal services provide care for babies as part of the birth episode and for some babies requiring care after they have returned home. Guidance for neonatal service capability related to services delivered as part of the birth episode are covered in NSW Health Guideline *Maternity and Neonatal Service Capability* (GL2022_002).
Networked services	Two or more interconnected health services that ensure continuity of patient care, especially for smaller or more remote services. This may include the use of virtual care.

Paediatric medicine services	Paediatric medicine services range from common and uncomplicated health care delivered in small facilities through to speciality medicine and intensive care services delivered in a Children's Hospital.
Paediatric safe bed or environment	A safe bed or space is an environment which meets the physical, developmental, social and emotional needs of infants, children and adolescents. See NSW Health Policy Directive *The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities* (PD2022_053) for further information.
Paediatric Service Capability Assessment Tools (PSCATs)	Tools that are used to guide paediatric service capability assessment. Tools are available on the Paediatric Service Capability page of the NSW Health Intranet.
Service capability	Service capability describes the activity and complexity of clinical care that a service can safely provide in collaboration through formal agreements with its supporting services (allied health, pathology, child protection services, and so on on). Services may be delivered face-to-face or through virtual care. It is the level of care a service anticipates delivering in business-as-usual practice.
Surgery for Children services	Surgery for Children services range from minor surgical procedures delivered in small facilities through to complex major surgical procedures delivered in a Children's Hospital. Surgery for children includes surgery provided by general and specialist adult surgeons, as well as paediatric surgery provided by specialist paediatric surgeons.
Transport and retrieval services	Provide transport and retrieval for patients requiring urgent or non-urgent transfer between paediatric and/ or neonatal services in NSW and the ACT. Medical retrieval services manage the transfer of critically ill or injured patients. Transport services provide non-emergency care during transfers to higher-level care or for return transfers. NSW Health Policy Directive *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019) provides detail on these arrangements.

Virtual care	Virtual care or telehealth is the delivery of healthcare at a distance using information communications technology such as phone and video conferencing. See the *NSW Virtual Care Strategy 2021-2026* for further information.

1.5. Related NSW Health documents

Policy Number	Policy Title
PD2013_007	*Child Wellbeing and Child Protection Policies and Procedures for NSW Health*
GL2016_027	*Neonatal – Jaundice Identification and Management in Neonates ≥32 Weeks Gestation*
PD2017_044	*Interpreters – Standard Procedures for Working with Health Care Interpreters*
PD2019_008	*The First 2000 Days Framework*
GL2019_008	*Communicating Positively: A Guide to Appropriate Aboriginal Terminology*
PD2019_056	*Credentialing and Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists*
PD2020_006	*Responding to Sexual Assault (adult and child) Policy and Procedures*
PD2020_018	*Recognition and management of patients who are deteriorating*
PD2022_023	*Enterprise-wide Risk Management*
PD2022_053	*The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities*
PD2023_009	*Domestic Violence Routine Screening*
PD2023_019	*NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements*

Other Related NSW Health Documents
NSW Aboriginal Health Plan 2013-2023
NSW Health Child Safe Action Plan 2023-2027
NSW Youth Health Framework 2017-24
Healthy, Safe and Well - A Strategic Health Plan for Children, Young People and Families 2014–24
National Safety and Quality Health Service Standards (Second edition) (Updated May 2021)
NSQHS Standards User Guide for Aboriginal and Torres Strait Islander health
NSW Health Guide to the Role Delineation of Clinical Services (2024)
NSW Health Virtual Care Strategy 2021-2026
NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026
NSW Eating Disorders Toolkit (Updated May 2021)
NSW LGBTIQ+ Health Strategy 2022-2027

Accessing inpatient mental health care for children and adolescents (2022)
Guide to understanding inpatient mental health admissions for children and adolescents (2022)
Minimum standards for coordinated delivery of paediatric rehabilitation in NSW Health (2022)
Future Health: Guiding the next decade of health care in NSW 2022-2032
NSW Regional Health Strategic Plan 2022-2032
Integrated Trauma-Informed Care Framework: My story, my health, my future (2023)
Children First 2022-2031

2. Paediatric Clinical Care in NSW

2.1. Care within local networking arrangements

Clinical care and inter-hospital transfers for infants, children and adolescents are delivered through a statewide system of networked care. Services providing paediatric health care include NSW Health services (inpatient and outpatient), NSW Health transport and retrieval services, and service partners in other jurisdictions. Services are linked through local networking arrangements.

NSW Health also provides care for paediatric patients whose care has been escalated from a NSW private hospital or through cross border arrangements. Higher-level services may also be provided to NSW patients through cross border arrangements such as with the ACT, Queensland, Victoria and South Australia.

Paediatric services partner with other health services across the continuum of care, including:

- emergency medicine
- community health
- child and family health
- youth health
- allied health
- oral health
- prevention and response to violence, abuse and neglect (VAN)
- child and youth mental health services
- primary care
- and non-government services (such as National Disability Insurance Scheme [NDIS] funded services).

Paediatric patients may require care at a higher level service than originally anticipated. Local health districts (districts) and specialty health networks (networks) are responsible for ensuring local arrangements are in place for clinical consultation and transfer of paediatric patients up and down the levels of services capability. NSW Health Policy Directive *NSW*

Paediatric Clinical Care and Inter-hospital Transfer Arrangements (PD2023_019) describes this system of care.

2.2. Services available across the range of capability

Districts/ networks are responsible for ensuring paediatric patients have access to the appropriate level and range of Paediatric Medicine and Surgery for Children services required, including specialist services. Services must be provided within the respective district or through agreed pathways under formalised local networking arrangements.

Networking is to support patients receiving care at a higher level service if required, as well as return transfers to the appropriate level of care close to home, as clinically appropriate. Outreach services, shared care and virtual care may also be used to enhance paediatric care, particularly in regional and rural areas.

In addition to medical and nursing care, services commonly required by paediatric patients include, but are not limited to:

- dietetics
- physiotherapy
- speech pathology
- occupational therapy
- psychology
- child life therapy, and
- social work.

Specialist services may include care for infants, children and adolescents and their families/ carers with complex social (such as impacted by trauma, violence, abuse and neglect, alcohol and other drug concerns), physical and/ or mental health needs.

2.3. Statewide services

Level 6 Paediatric Medicine and Surgery for Children services have a statewide role, which means they provide specialist services required by infants, children and adolescents referred from anywhere in NSW/ ACT. Level 6 care is provided by the three NSW Children's Hospitals:

- the Sydney Children's Hospitals Network (SCHN) hospitals based at Randwick and Westmead, and
- the John Hunter Children's Hospital (JHCH) based in Newcastle.

All three hospitals provide statewide interventional radiology, trauma care and cardiology services for infants, children and adolescents. Cardiac surgery and specialist spinal injury services are provided by SCHN. Statewide services are provided for severe burns at SCHN (Westmead campus). Specialist services may be provided in the Children's Hospitals or via virtual care or specialised outreach and support to local services so care can be provided close to home wherever possible.

2.4. Leadership and support

Districts/ networks are to have local arrangements in place to provide clinical and strategic leadership for Paediatric Medicine and Surgery for Children services. The Henry Review recommended each district appoints a 'LHD Medical Lead in paediatrics' (Recommendation 21). The report noted there will be a co-lead from nursing and in some cases the leadership will be across both paediatrics and child health.

2.4.1. Local Health District lead for paediatrics

The role of LHD Paediatric Medical Leads includes but is not limited to leadership of:

- strategic advice at the district executive level
- development and implementation of paediatric models of care including models for adolescents
- clinical peer group networks
- policy development and implementation
- safety and quality in paediatric healthcare, including cultural safety and equity of access
- developing a district-wide networked and coordinated approach to care across all health care settings including community, emergency department, ambulatory and inpatient settings
- identifying and addressing gaps in capability and capacity to provide paediatric medical and surgical services across the district, including the multidisciplinary team
- implementation of this Guideline, including annual reporting
- development and implementation of a local annual operational plan in collaboration with relevant service managers.

2.4.2. Support from higher level services

Within formalised local networking arrangements, higher level services are responsible for providing lower level services with support, advice and management of paediatric patients. The benefit of this is twofold - capability building for management of patients and networked service delivery.

Support from higher level services may take the form of:

- multidisciplinary clinical advice, shared care, provision of clinical services such as outreach clinics (face-to-face or virtual)
- participation in clinical safety and quality processes, development of clinical guidelines, training and education.

While any service can provide support for services at a lower capability level, Levels 4, 5 and 6 services have specific roles. Minimum requirements for each service capability level are outlined in the tables in Section 7.

2.5. Enhancing service capability through virtual care

Districts/ networks must leverage virtual care to optimise the capability of services and delivery of care close to home. Use of virtual care or telehealth means healthcare can be provided at a distance using information communications technology such as phone and video conferencing.

Communications technology can enable and facilitate a diverse range of activities that support paediatric service capability, including but not limited to:

- clinical support and advice, including specialist consultation on time-critical treatment
- scheduled clinical care (such as paediatric clinics)
- case conference and clinical reviews with the multidisciplinary team and between higher and lower-level services (including to support transitions in care)
- education and training of clinicians (such as case discussions, debriefs and grand rounds)
- engagement in safety and quality activities (including morbidity and mortality meetings, policy meetings and clinical case reviews).

Districts/ networks are to ensure staff are trained in the use of technologies to support virtual care (such as telehealth) and related clinical practice (such as electronic Medical Records).

3. Service Capability

To provide appropriate clinical care and inter-hospital transfers for paediatric patients, NSW Health services must operate at their designated service capability level within agreed local health service arrangements and in partnership with transport and retrieval services and other key service partners. NSW Health services may also have local arrangements with bordering jurisdictions for paediatric clinical care.

Local health districts (districts) and specialty health networks (networks) are to optimise appropriate paediatric care close to home through services operating at their designated service capability level and actively managing patient flow.

3.1. Levels of service capability

Paediatric Medicine service capability levels are 2, 3, 4, 5 and 6. Surgery for Children service capability levels are 2, 3, 4 and 6. There is no level 5 for Surgery for Children services. The 'highest' or most complex level of care is provided by Level 6 services.

The levels are outlined in Section 7 and service capability tables identify the optimal criteria for each level. The levels build on each other, which means services will meet the requirements at their designated level as well as the requirements for the levels below. Assessment of service capability is described in Section 6.

3.1.1. No planned Paediatric Medicine and Surgery for Children services

This Guideline is for Paediatric Medicine and Surgery for Children services, but also recognises that some facilities without these services (such as Multipurpose Services) will at times need to provide urgent and essential services to infants, children and adolescents. Minimum requirements for these services are addressed in Section 7.2.

3.1.2. Additional supported services

Paediatric Medicine and Surgery for Children services may choose to provide some aspects of care that are above their designated service capability level, these are referred to as 'additional supported services'. Additional supported services require the appropriate corresponding minimum core services (see *NSW Health Guide to the Role Delineation of Clinical Services* [2024]). For examples of additional supported services for Paediatric Medicine Levels 3, 4 and 5 see Sections 7.3.2, 7.3.3 and 7.3.4 respectively; and for Surgery for Children Levels 3 and 4 see Sections 7.4.2 and 7.4.3 respectively. They are indicative examples only and not an exhaustive list.

Where an aspect of higher-level care is identified as needed to meet local service requirements, the district is to undertake a multidisciplinary risk assessment process. This process is to assess the local services required to deliver the higher-level care on an ongoing basis. The outcome of the assessment may require moving up a service capability level if all criteria for the higher level are consistently met. Assessment processes require district executive approval of the designated service capability level.

Additional supported services are to be communicated to service partners within local networking arrangements and can be highlighted in information for consumers and the public about local service capability.

3.2. Paediatric Medicine and Surgery for Children service relationships

Paediatric Medicine and Surgery for Children services partner with each other for clinical advice and support in the care for infants, children and adolescents. The partnering services are to be co-located or linked in formal networking arrangements. The level of service capability of partnering services must support the safe, high-quality clinical care of paediatric patients and their families/ carers.

3.3. Private hospital levels

Private hospital paediatric care is a valued service option for many families. Private hospitals with paediatric class facilities partner with public services through formalised networking arrangements. The levels of private facilities do not follow the same service capability levels as public services. Private services are licensed under the *Private Health Facilities Act 2007* (NSW) and the *Private Health Facilities Regulation 2017* (NSW). Schedule 2 Part 14 of the Regulation identifies the requirements for private paediatric class facilities.

4. Service Capability and Risk

Risks must be managed to ensure patient safety. Risks applicable to service capability relate to services being able to continually operate at their designated service capability level, and responding when a higher level of care is required for a patient.

4.1. Managing risks to continually operating at the designated service capability level

Local risk management processes must be in place for situations when a service is unable to meet the optimal criteria for its designated service capability level. Assessment processes to determine service capability outlined in Section 6.1 support risk assessment and management as they help identify gaps and areas for enhancement. Particular attention must be paid to risk management strategies where there are identified risks to service sustainability, such as a service that relies on a limited clinical workforce pool or sole practitioner in a specialty or subspecialty.

The risk management response needs to be timely, documented and implemented in accordance with relevant health policies including NSW Health Policy Directive *Enterprise-wide Risk Management* (PD2022_023) and endorsed by the appropriate health service Chief Executive or delegate.

For planned changes to service capability level, local health districts (districts) must follow the assessment and notification advice in Section 6. In emergency service provision circumstances, Critical Operations Standard Operating Procedures or Business Continuity Plans will apply.

4.2. Managing clinical risk when a higher level of care is required

The service capability tables outline standards to support safe paediatric care at each service capability level. Three appendices to this Guideline assist services in assessing clinical risk. These appendices are to be used as a guide only and do not replace clinical judgement:

- Appendix 2 outlines the various factors impacting clinical risk in anaesthesia.
- Appendix 3 identifies increasing complexity of surgical procedures.
- Appendix 4 provides guidance on the scope of care for each of the Surgery for Children service capability levels.

Local processes must be in place to ensure that pre-booked care is scheduled at the appropriate service capability level. Risks must be assessed and where requirements for higher-level care are anticipated, care must be pre-planned with higher-level services.

4.2.1. Clinical escalation and transfer

There may be occasions when the care of an individual patient becomes complicated. It is vital that efficient and safe mechanisms are in place to facilitate consultation or referral. A

higher level of service may be required than originally anticipated. Urgency and escalation to the appropriate higher-level service must be congruent with the patient's level of risk.

Clinical care and risk management are to be provided in line with NSW Health Policy Directives, including but not limited to:

- *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019)
- *Recognition and management of patients who are deteriorating* (PD2020_018)
- *The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities* (PD2022_053).

Risks related to managing patient flow and clinical escalation are to be addressed in line with the *NSW Ministry of Health Demand Escalation Framework* (2016) and NSW Health Policy Directive *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019).

If a paediatric patient is identified as requiring care that is outside the service capability of their local service and a transfer to a higher-level service is required, the clinician must discuss the recommended care with the patient and family/ carers (as appropriate). They must also be advised that once specialised care is no longer required, the patient will usually be transferred back to a service with the capability to provide appropriate ongoing care that is as close to home as possible.

4.2.2. Managing clinical risk when transfer to higher level care is not possible

Circumstances may arise where transfer to a higher level of care, although indicated, may not be possible. This may occur, for example, if transport is delayed (such as weather-related issues) or a paediatric patient (or family/ carer) is reluctant to access the recommended care. Reluctance may be due to the impact of transfer including travel and accommodation logistics and/ or costs, and isolation from family and support structures. This situation may arise more often in regional and rural areas. It may also be a particular concern for Aboriginal families preferring to stay on country or close to home.

Clinicians need to balance local service capability and outreach, shared care and virtual care supports from higher-level services against the impact of transfer to a higher-level service on the patient and family/ carers. Clinicians must acknowledge and respect patient and family/ carer opinions and their right to be informed of the risks and benefits of care options.

Patients and families/ carers must be supported to make informed decisions and be provided with culturally appropriate and accessible information on all options for care. If appropriate, they are to be offered support through:

- Aboriginal health workers, Aboriginal maternal, infant and child health programs (such as Aboriginal Maternal Infant Health Services [AMIHS] and Building Strong Foundations [BSF])
- interpreters (see NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* [PD2017_044]) and other cultural and diversity supports

- social workers, and
- other services and supports as required.

If an occasion arises where a service needs to temporarily provide urgent and essential care outside its designated service capability level, it must follow local policy and procedures and:

- guidance outlined in NSW Health Policy Directive *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019) including seeking advice and support on the patient's clinical management plan from their locally networked on-call paediatrician or higher-level service and other relevant services (such as retrieval services)
- consult locally with other clinicians and service managers regarding any proposed procedure and impact on related services within the service
- ensure that the infant, child or adolescent is cared for in the most appropriate environment within the local service (such as emergency department, close observation bed, intensive care unit)
- discuss in detail with the patient and family/ carers (where relevant) any potential risks to the patient, so they can make informed decisions regarding recommendations for care. This discussion must be documented in the patient's medical record.

5. Communicating Service Capability

5.1. Communicating with patients and families

Accessible and culturally appropriate information about the capability level of a service must be provided to patients and their families/ carers. This will help them understand what can be provided at the service and what to expect if transfer for a higher level of care or return transfer is required. It will also support them in making decisions about their care.

Information and communication should consider the needs of people with low health-literacy and communication disabilities. It should also be developmentally appropriate. Standard consumer factsheets are available on the Paediatric Service Capability page of the NSW Health Intranet.

Appropriate services must be engaged to assist with communication. Patients and families/ carers who are not fluent in English, or who have a hearing impairment or other communication disability need to be offered interpreter services (see NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* [PD2017_044]) or other supports to assist them with these discussions.

Aboriginal patients and their families/ carers must also be offered communication support by being linked with Aboriginal Liaison Officers or Aboriginal Health Workers.

5.2. Communicating with the public

Current information about the service capability of local paediatric services must be available to the public. This may include, for example, information on the local health district (district)/

specialty health network (network) paediatrics website, a poster on the ward and flyers given to patients and families/ carers. Standard consumer factsheets are available on the Paediatric Service Capability page of the NSW Health Intranet.

6. Assessment, Notification and Reporting

6.1. Service capability assessment

An initial assessment of service capability is to be undertaken when establishing a new Paediatric Medicine or Surgery for Children service. Re-assessments are to be carried out:

- whenever there is a planned change to service level
- regularly at the discretion of the local health district (district)/ specialty health network (network) to support safety and quality practices linked to the district/ network clinical services planning cycles
- to fulfil NSW Ministry of Health reporting requirements (see Section 6.2).

An assessment of service capability is conducted by reviewing the tables in Section 7 of this Guideline in conjunction with the *NSW Health Guide to the Role Delineation of Clinical Services* (2024) and NSW Health Guideline *Maternity and Neonatal Service Capability* (GL2022_002). Districts are to use the Paediatric Service Capability Assessment Tool (PSCAT) to record and report on service capability. The PSCAT can be found on the on the Paediatric Service Capability page of the NSW Health Intranet.

Use of the PSCAT provides a rapid review of service capability which can help districts/ networks identify issues that require a documented risk assessment. Risk assessments must be completed in line with current NSW Health policy directives. If a service does not meet all criteria at a specific level, risk management and service development plans must be in place to address any capability gaps.

A comprehensive assessment involves site visits and detailed review of current processes and resources. A high-level assessment may involve a desktop review of services. In either form, it is a collaborative exercise, with leadership from the LHD Paediatric Medical Lead, senior management and health service planning and completed in partnership with clinical representatives from paediatric and related clinical services including nursing, allied health and Aboriginal health services. Sign off is by the district/ network Chief Executive.

Consideration can also be given to involving an independent expert to participate in the assessment process to contribute additional objectivity and expertise, for example, a senior clinician or manager from within local networking arrangements. Districts/ networks may also involve children/ young people and families/ carers in the assessment process to provide a consumer perspective.

6.2. Reporting of service capability levels

The NSW Ministry of Health will request from district/ network Chief Executives a report of Paediatric Medicine and Surgery for Children service capability levels as follows:

- A comprehensive assessment including a risk management and service development plan within 6 months of the release of this Guideline.
- An update on service levels and risk management and service development plans each May/ June (a comprehensive assessment is not required at this time but may be completed).
- An ad-hoc report at any time, as required.

Routine statewide reporting of service capability will assist the NSW Ministry of Health in statewide planning for Paediatric Medicine and Surgery for Children services. Templates for reporting can be found on the Paediatric Service Capability page of the NSW Health Intranet.

6.3. Notification of changes to service capability

To maintain safe and efficient care, districts/ networks must have local processes in place to communicate with key partners in a timely manner any changes to a Paediatric Medicine or Surgery for Children service capability level. This includes a move to a lower or higher level of capability. Stakeholders will include partnering local health services and Level 6 services, NSW Ambulance and the Newborn and paediatric Emergency Transport Service (NETS).

In line with the *Health Services Act 1997* (NSW), the Secretary of NSW Health must be notified in advance of any planned commencement of a new service and/ or closure or restriction of the range of services offered by districts and networks.

A planned move to a lower service capability level would constitute a planned restriction of service. The requirements to notify the NSW Ministry of Health are for planned changes and do not apply to emergency service provision circumstances where Critical Operations Standard Operating Procedures or Business Continuity Plans apply. The notification form can be found on the Paediatric Service Capability page of the NSW Health Intranet.

7. Service Capability Tables

7.1. Overview of tables

The following tables outline the recommended components at each of the service levels. The tables describe the components required to deliver a service at each capability level:

- Service scope: scope of services, capabilities and resources
- Minimum core services: anaesthetics, operating suite, intensive care service, nuclear medicine, radiology, pathology and pharmacy
- Clinical governance: guiding documents for service provision, competence and credentialing, quality and safety processes
- Service requirements: consultation, escalation and transfer, and education
- Workforce: workforce and consultation
- Examples of additional supported services.

7.1.1. Service capability table key

	No planned Paediatric Medicine or Surgery for Children service

Paediatric Medicine Services	
	Level 2
	Level 3
	Level 4
	Level 5
	Level 6

Surgery for Children Services	
	Level 2
	Level 3
	Level 4
	Level 6

7.2. No planned Paediatric Medicine or Surgery for Children services

NO PLANNED PAEDIATRIC MEDICINE OR SURGERY FOR CHILDREN SERVICES

A service without any Paediatric Medicine or Surgery for Children service, provides:

- pathway for consultation (access to expert advice), escalation and/ or transfer if an infant, child or adolescent presents for care
- documented arrangements with Newborn and paediatric Emergency Transport Service (NETS) and NSW Ambulance in line with NSW Health Policy Directive *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (PD2023_019)
- Clinical Emergency Response Systems (CERS) for recognition of, and response to clinical deterioration as outlined in NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018)
- escalates to a networked higher level service when additional care or admission is required.

7.3. Paediatric Medicine services

7.3.1. Level 2 Paediatric Medicine service

LEVEL 2 PAEDIATRIC MEDICINE SERVICE	
SERVICE SCOPE	
Provides: • clinical care for infants, children and adolescents presenting to the service in line with the Emergency Medicine service standard[2] and escalates to a networked higher level service when required • short-term inpatient care where required (up to 48 hours) for infants, children and adolescents with common and uncomplicated medical conditions[3], usually in regional and rural locations. Contacts the local or regional paediatrician at time of admission or within 12 hours of presentation and at least daily thereafter[4]. **Does not provide:** • paediatric admissions for >48 hours or admissions for infants, children and adolescents with more complex problems.	
Capabilities	**Resources**
Identification of and responses to medical needs and psychosocial issues. Provides education and support for parents/ carers. Escalates care to higher level service when additional care is required or in response to signs of clinical deterioration[5].	On-site: • Capacity to provide a paediatric safe bed[6]. • Appropriate medication and drug dose resources for infants, children and adolescents.

[2] *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Emergency Medicine.

[3] According to clinical judgement.

[4] Refer to NSW Health Policy Directive *The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities* (PD2022_053)

[5] In line with Clinical Emergency Response Systems (CERS) for recognition of, and response to, paediatric clinical deterioration (refer to NSW Health Policy Directive *Recognition and management of patients who are deteriorating* [PD2020_018]).

[6] A safe bed or space is an environment which meets the physical, developmental, social and emotional needs of children and adolescents (refer to NSW Health Policy Directive *The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities* [PD2022_053]).

	• Appropriate equipment for infants, children and adolescents (including resuscitation). • Equipment and processes to support virtual care. • Access to paediatric clinical practice guidelines (such as Clinical Practice Guidelines). • Consumer information on service capability.

MINIMUM CORE SERVICES (with capacity to treat children)

As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	1	1	–	–	1	1	1

CLINICAL GOVERNANCE

Guiding documents for service provision	Local protocols (including formal networking arrangements) for:
	• consultation, escalation and transfer processes
	• collaboration with Emergency Medicine services
	• admission, transfer and discharge criteria and processes that reflect local, cross LHD/ SHN and interstate arrangements (where required)
	• retrieval processes with Newborn and paediatric Emergency Transport Service (NETS) or NSW Ambulance and where relevant, interstate service provider/s
	• process for non-emergency transfer and transport (including equipment requirements)
	• identifying infants, children and adolescents, and families at risk, including risk of harm and those who have suffered reported or suspected physical and/ or sexual abuse or neglect and facilitating access to appropriate agencies or support services
	• processes for communication with, referral pathways and timely access to:
	  ○ Aboriginal support, programs and services
	  ○ support, programs and services for priority populations, such as from culturally and linguistically diverse (CALD) backgrounds, other diverse backgrounds and infants, children and adolescents and families with a disability
	  ○ primary care, community health, child and family health, youth health, allied health, oral health, child and youth mental health services, and alcohol and other drugs services

	○ prevention and response to violence abuse and neglect services (such as sexual assault, domestic and family violence and child protection services) ○ other partner services to support integrated care such as Department of Education, Department of Communities and Justice, and specialised services and supports such as youth support non-government organisations (NGOs) and/ or homelessness services. • optimising access for paediatric patients to appropriate care close to home through services operating at their designated service capability level and actively managing patient flow • service contingency plans to cover a temporary move to a lower service capability level, including process for informing partnering services including NETS and NSW Ambulance.
Competence and credentialing	Processes to ensure clinical staff are appropriately credentialed and work within their clinical privileges (such as NSW Health Policy Directive *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* (PD2019_056), NSW Health Model Scopes of Clinical Practice – Paediatric).
Quality and safety processes	Patient safety and quality incidents are recognised, reported and analysed by the multidisciplinary team and information used to improve safety. Quality and risk management programs are in line with current National Safety and Quality Health Service (NSQHS) standards. Child Safe Standards are implemented (such as processes to support infants, children and adolescents to have a voice in their care). Ongoing formal peer review process for reviewing clinical outcomes in consultation with networked services.
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	Consultation, escalation and transfer arrangements are in place with local and regional paediatric services and statewide paediatric services, including NETS and NSW Ambulance (or relevant interstate service provider/s). Clinical Emergency Response Systems (CERS) for recognition of, and response to clinical deterioration. Child Abuse and Sexual Assault Clinical Advice Line.
Education	Local clinical education and access to training through local arrangements with higher-level services. Access to online paediatric training (such as the Health Education and Training Institute [HETI]).
WORKFORCE	

Workforce and consultation	Local Health District (LHD) medical lead for paediatrics. Paediatric consultation available via networked paediatrician (may be via virtual care). Medical practitioner available 24 hours for admitted patients (includes on-call for on-site consultation). Nursing – Refer to Appendix 1. Access to allied health professionals, such as social worker, physiotherapist, occupational therapist, speech pathologist and dietitian (may include virtual care). Access to Aboriginal practitioners or workers, preferably both male and female (may be via virtual care).

7.3.2. Level 3 Paediatric Medicine service

LEVEL 3 PAEDIATRIC MEDICINE SERVICE

SERVICE SCOPE

As for Level 2 and in addition **provides:**

- inpatient care for paediatric patients with common and uncomplicated medical conditions[7] led by a medical practitioner (such as general practitioner (GP) and/ or paediatrician)
- post-acute follow-up care (such as acute review clinic, GP, paediatrician, outpatient clinic)
- acceptance of appropriate return transfers of patients from higher-level Paediatric Medicine services.

Does not provide:

- definitive care for infants, children and adolescents with complex conditions and/ or comorbidities requiring admission for subspecialty services.

Capabilities	Resources
As for Level 2 and in addition: • post-acute care escalates care to higher-level service when additional care is required or in response to signs of clinical deterioration[8].	As for Level 2 and in addition: • paediatric safe environment • close observation service

[7] According to clinical judgement

[8] In line with Clinical Emergency Response Systems (CERS) for recognition of, and response to, paediatric clinical deterioration.

	• may have access to ultrasound[9] • equipment and processes to support virtual care at bedside.

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	3	3	–	–	3	3	3

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Level 2
Competence and credentialing	As for Level 2
Quality and safety processes	As for Level 2
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Level 2
Education	As for Level 2
WORKFORCE	
Workforce and consultation	As for Level 2 and in addition: • Paediatrician lead for service (may be via networking arrangements). • Medical practitioner credentialed to treat paediatric patients, available 24 hours (may be on call). • Nursing – Refer to Appendix 1.

[9] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology

	• Allied health professionals, such as physiotherapist, occupational therapist, social worker, speech pathologist and/ or dietitian (preferably with a specific paediatric caseload).
LEVEL 3 PAEDIATRIC MEDICINE SERVICE – EXAMPLES OF ADDITIONAL SUPPORTED SERVICES	
Day only (short stay) service and/ or paediatric hospital in the home (HITH) services.	

7.3.3. Level 4 Paediatric Medicine service

LEVEL 4 PAEDIATRIC MEDICINE SERVICE
SERVICE SCOPE

As for Level 3 and in addition **provides:**

- paediatric inpatient and non-admitted care for patients with a broad range of medical conditions, delivered by a dedicated[10] multidisciplinary team and led by a paediatrician
- inpatient care delivered in a paediatric ward
- acute review and day only (short stay) services
- a range of paediatric outpatient services delivered face to face or via virtual care to meet local need
- referral pathways to subspecialty services (such as endocrinology, cardiology, neurology)
- acceptance of appropriate return transfers of patients from Level 6 Paediatric Medicine services
- paediatric support and outreach to networked lower-level services within the local health district/ specialty health network including clinical advice and professional development support.

Does not provide:

- a comprehensive range of paediatric specialty services.

Capabilities	Resources
As for Level 3 and in addition: • specialist paediatric services for infants, children and adolescents with a broad range of medical conditions and comorbidities[11] including eating disorders	As for Level 3 and in addition: • close observation service • paediatric ward including ability to isolate in a single room • access to pathology and radiology under sedation or anaesthesia • access to ultrasound and Computed Tomography (CT) scanner[13]

[10] Resource (such as staff or space) used for a particular purpose. Need not be used exclusively for this purpose (Refer to *NSW Health Guide to the Role Delineation of Clinical Services* [2021] (Appendix VI Glossary).

[11] According to clinical judgement

[13] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology

• multidisciplinary approach to assessment and management of conditions (including developmental, psychosocial and behavioural issues) • paediatric rehabilitation in line with *Minimum standards for coordinated delivery of paediatric rehabilitation in NSW Health* • transitions care of adolescents to adult services • works with intensive care services to provide emergency stabilisation and support for paediatric patients prior to transfer to specialist children's hospital. • escalates care to higher level service when additional care is required or in response to signs of clinical deterioration[12].	• access to electroencephalogram [EEG] (may be networked)[14] • may have adolescent area available.

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	4	4	4	4	4	4	4

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Levels 2 and 3 and in addition: • process for transition of adolescents to adult services.
Competence and credentialing	As for Levels 2 and 3
Quality and safety processes	As for Level 3 and in addition: • participates in clinical safety and quality processes of lower-level sites in local health district.
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Level 3 and in addition:

[12] In line with Clinical Emergency Response Systems (CERS) for recognition of, and response to, paediatric clinical deterioration

[14] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Neurology

	• established systems for return transfer of infants, children and adolescents • processes for transitioning the care of adolescents to adult services • formalised agreements for access to child and youth mental health services for consultation and/ or liaison during business hours, and access to general mental health services for consultation and/ or liaison after hours • access to a broad range of allied health specialties including orthoptics, audiology and genetic counselling • access to prevention of violence abuse and neglect services (such as sexual assault, domestic and family violence and child protection services) • access to local subspecialty services (such as neurology, cardiology) such as local general (adult) subspecialty services or subspecialty services delivered with a Paediatric Medicine Level 6 service including via outreach or shared appointments • access to local intensive care services.
Education	As for Level 3 and in addition: • active program of undergraduate and postgraduate teaching across professions.
WORKFORCE	
Workforce and consultation	As for Level 3 and in addition: • Paediatrician head of service. • Paediatrician available 24 hours (May be on call. Working 1 in 4 roster or less frequently[15]). • Consultation via networking arrangements with a range of medical specialists with subspecialty credentials (such as neurology, endocrinology, respiratory). • Medical practitioner with at least 3+ postgraduate years of experience (including in paediatrics), available 24 hours (on-site). • Nursing – Refer to Appendix 1. • Allied health professionals with specific paediatric caseload on-site (such as psychologist, occupational therapist, physiotherapist, speech pathologist, dietitian and social worker).
LEVEL 4 PAEDIATRIC MEDICINE SERVICE – EXAMPLES OF ADDITIONAL SUPPORTED SERVICES	
Paediatric hospital in the home (HITH) services. Anaesthesia for children <36 months of age.	

[15] Henry Review Recommendation 22: The on-call roster for a level 4 paediatric facility be no more onerous than 1 in 4.

7.3.4. Level 5 Paediatric Medicine service

LEVEL 5 PAEDIATRIC MEDICINE SERVICE	
SERVICE SCOPE	
As for Level 4 and in addition **provides**: • dedicated comprehensive multidisciplinary services for infants, children and adolescents (inpatient, outpatient and via virtual care) • a broad range of paediatric subspecialty services provided face to face or via virtual care to meet local need • services delivered 7 days per week via comprehensive non-inpatient models including ambulatory care, short stay and acute review services provided in a dedicated area; paediatric hospital in the home service • paediatric support and outreach to networked lower-level services within the local health district/ specialty health network including clinical advice and professional development support • integrated care with non-inpatient services for infants, children and adolescents (such as child development, child and youth mental health, child protection services) • co-located minimum level 4 neonatal service (see NSW Health Guideline *Maternity and Neonatal Service Capability* [GL2022_022]). **Does not provide**: • definitive Paediatric Intensive Care services.	
Capabilities	**Resources**
As for Level 4 and in addition: • staff with advanced knowledge and skills in speciality area (such as endocrinology, neurology) • paediatric rehabilitation in line with *Minimum standards for coordinated delivery of paediatric rehabilitation in NSW Health*.	As for Level 4 and in addition: • close observation service • access to magnetic resonance imaging (MRI)[16] • electroencephalogram (EEG) available on-site[17].

[16] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology
[17] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Neurology

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	5	5	5	5	5	5	5

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Levels 2, 3, 4
Competence and credentialing	As for Levels 2, 3, 4
Quality and safety processes	As for Level 4
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Level 4 and in addition: • access to youth health services, such as adolescent clinics.
Education	As for Level 4
WORKFORCE	
Workforce and consultation	As for Level 4 and in addition: • Medical practitioner with at least 3+ postgraduate years of experience (including 1 year in paediatrics), available 24 hours on-site (dedicated to paediatrics). • Allied health professionals with specific paediatric caseload on-site (such as psychologist, occupational therapist, physiotherapist, speech pathologist, dietitian, social worker and child life therapist) and after-hours access to general (adult) allied health professionals.

LEVEL 5 PAEDIATRIC MEDICINE SERVICE – EXAMPLES OF ADDITIONAL SUPPORTED SERVICES
Paediatric support and outreach to networked lower-level services outside the LHD/ SHN including clinical advice and professional development support.

7.3.5. Level 6 Paediatric Medicine service

LEVEL 6 PAEDIATRIC MEDICINE SERVICE	
SERVICE SCOPE	
As for Level 5 and in addition **provides**: • paediatric intensive care • paediatric medicine subspecialty services on-site for infants, children and adolescents • comprehensive multidisciplinary care for infants, children and adolescents with complex medical conditions and comorbidities[18] • paediatric subspecialty support to lower-level services including clinical advice and professional development • paediatric subspecialty clinical advice for transport and retrievals • paediatric subspecialty outreach services • hospital in the home (HITH) services. Statewide and ACT reach. Interstate and international service provision by negotiation.	
Capabilities	**Resources**
As for Level 5 and in addition: • paediatric subspecialty services (inpatient, outpatient and via virtual care)	As for Level 5 and in addition: • Magnetic resonance imaging (MRI) on-site[19] • Adolescent area

[18] According to clinical judgement

[19] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology

MINIMUM CORE SERVICES (services for children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	5	5	5	6	6	6	6
	Minimum Core Services refer to services with capacity to treat children						

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Levels 2, 3, 4, 5
Competence and credentialing	As for Levels 2, 3, 4, 5
Quality and safety processes	As for Level 5
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Level 5: • facilitates return transfer of infants, children and adolescents.
Education	As for Level 5
WORKFORCE	
Workforce and consultation	As for Level 5 and in addition: • Subspecialty paediatricians on call 24 hours. • Medical practitioner in paediatrics with at least 3+ postgraduate years of experience in paediatrics, available 24 hours on-site. • Nursing – Refer to Appendix 1. • Allied health professionals with skills in paediatric subspecialties on-site (such as psychologist, occupational therapist, physiotherapist, speech pathologist, dietitian, social worker, child life therapist, orthoptist, music therapist, audiologist and genetic counsellor).

7.4. Surgery for Children services

7.4.1. Level 2 Surgery for Children service

LEVEL 2 SURGERY FOR CHILDREN SERVICE
SERVICE SCOPE

Provides:

Minor surgical procedures[20] for infants, children and adolescents of any age with American Society of Anesthesiologists (ASA) Level 1 and 2 risk[21] completed with local anaesthesia

- minor surgical procedures for children aged 36 months or over with ASA Level 1 and 2 risk completed with local anaesthesia with conscious sedation
- escalates to a networked higher-level service when required
- time-critical procedures for infants, children and adolescents with a life or limb threatening conditions in consultation with a Level 4 or 6 Surgery for Children service.

Does not provide:

- elective surgery for infants, children or adolescents under general anaesthesia
- procedures under general anaesthesia.

Capabilities	Resources
Escalates care to higher level service when additional care is required.	On-site: • Appropriate medication and drug dose resources for infants, children and adolescents. • Appropriate equipment for infants, children and adolescents (including resuscitation). • Equipment and processes to support virtual care. • Consumer information on service capability.

[20] Refer to Appendix 3 - Indicative list of surgery for children and Appendix 4 - Surgical complexity at each service capability level

[21] Refer to Appendix 2 - Levels of patient risk related to anaesthesia

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	1	1	–	–	1	1	1

CLINICAL GOVERNANCE	

Guiding documents for service provision	Local protocols (including formal networking arrangements) for:
	• consultation, escalation and transfer processes
	• collaboration with Emergency Medicine services
	• admission, transfer and discharge criteria and processes that reflect local, cross LHD/ SHN and interstate arrangements (where required)
	• retrieval processes with Newborn and paediatric Emergency Transport Service (NETS), NSW Ambulance and where relevant, interstate service provider/s
	• process for non-emergency transfer and transport (including equipment requirements)
	• identifying infants, children and adolescents, and families at risk, including risk of harm and those who have suffered reported or suspected physical and/ or sexual abuse or neglect and facilitating access to appropriate agencies or support services
	• processes for communication with, referral pathways and timely access to:
	  ○ Aboriginal support, programs and services
	  ○ support, programs and services for priority populations, such as from culturally and linguistically diverse (CALD) backgrounds, other diverse backgrounds and infants, children and adolescents and families with a disability
	  ○ primary care, community health, child and family health, youth health, allied health, oral health, child and youth mental health services, and alcohol and other drugs services
	  ○ prevention and response to violence, abuse and neglect services (such as sexual assault, domestic and family violence and child protection services
	  ○ other partner services to support integrated care such as Department of Education, Department of Communities and Justice, and specialised services and supports such as youth support non-government organisations (NGOs) and/ or homelessness services.
	• optimising access for paediatric patients to appropriate care close to home through services operating at their designated service capability level and actively managing patient flow

	• service contingency plans to cover a temporary move to a lower service capability level, including process for informing partnering services including NETS and NSW Ambulance.
Competence and credentialing	Processes to ensure clinical staff are appropriately credentialed and work within their clinical privileges (such as NSW Health Policy Directive *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* (PD2019_056), NSW Health Model Scopes of Clinical Practice: General Surgery, Paediatric Surgery) or NSW Health Policy Directive *NSW Health Nurse Practitioners* (PD2022_057).
Quality and safety processes	Patient safety and quality incidents are recognised, reported and analysed by the multidisciplinary team and information used to improve safety. Quality and risk management programs are in line with current National Safety and Quality Health Service (NSQHS) standards. Child Safe Standards are implemented (such as processes to support infants, children and adolescents to have a voice in their care). Ongoing formal peer review process for reviewing clinical outcomes in consultation with networked services.
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	Consultation, escalation and transfer arrangements are in place with local, regional and statewide Surgery for Children services, including NETS and NSW Ambulance (or relevant interstate service provider/s). Clinical Emergency Response Systems (CERS) for recognition of, and response to clinical deterioration. Child Abuse and Sexual Assault Clinical Advice Line.
Education	Local clinical education and access to training through local arrangements with higher-level services. Access to online paediatric training (such as the Health Education and Training Institute [HETI]).
WORKFORCE	
Workforce and consultation	Local Health District (LHD) medical lead for paediatrics. Paediatrician consultation available via networked paediatrician (may be via virtual care). Anaesthetic consultation available via networked arrangements (may be via virtual care). Medical practitioner available 24 hours (may include on-call or CERS Assist). Surgical consultation available via networked arrangements (may be via virtual care). Nursing – Refer to Appendix 1. Access to allied health professionals, such as physiotherapist, occupational therapist, social worker, speech pathologist and dietitian (may include virtual care). Access to Aboriginal practitioners or workers, preferably both male and female (may be via virtual care).

7.4.2. Level 3 Surgery for Children service

LEVEL 3 SURGERY FOR CHILDREN SERVICE
SERVICE SCOPE

As for Level 2 and in addition **provides**[22]:

- services for infants, children and adolescents at or above the age limit determined for the surgical specialty and hospital
- minor surgical procedures[23] for children aged 36 months or over with American Society of Anesthesiologists (ASA) level 1 to 3[24] risk completed with local anaesthesia with conscious sedation - specific consideration related to credentialing and clinical privileges for <36 months
- minor and common and intermediate surgical procedures for children aged 36 months or over with ASA level 1 and 2 risk completed with general anaesthesia - specific consideration related to credentialing and clinical privileges for <36 months
- day-only surgery
- post-acute follow-up care.

May provide:

- overnight admissions.

Does not provide:

- complex Major surgical procedures.

Capabilities	Resources
As for Level 2 and in addition: • surgical services under sedation or general anaesthesia • post-acute care	As for Level 2 and in addition: • paediatric safe environment • close observation service • may have access to ultrasound[26]

[22] These limits are intended as a guide only and do not replace clinical judgement. Patient selection should be determined following preadmission assessment. Local models of care for elective surgery in children, supported by effective clinical governance may include networked arrangements with a higher-level service.

[23] Refer to Appendix 3 - Indicative list of surgery for children and Appendix 4 - Surgical complexity at each service capability level

[24] Refer to Appendix 2 - Levels of patient risk related to anaesthesia

[26] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology

• consultation with Paediatric Medicine services for patients with complex medical problems, diagnostic uncertainty or in response to signs of clinical deterioration[25] • escalates care to higher level service when additional care is required.	• access to paediatric clinical practice guidelines (such as Clinical Practice Guidelines, College Guidelines such as ANZCA Anaesthesia in children – PG29[A]).

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	3	3	–	–	3	3	3

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Level 2
Competence and credentialing	As for Level 2
Quality and safety processes	As for Level 2
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Level 2
Education	As for Level 2
WORKFORCE	
Workforce and consultation	As for Level 2 and in addition: • Head of Service role (Surgery or Anaesthesia) that includes Surgery for Children services. • Medical practitioner credentialed in anaesthesia available 24 hours (may include on-call). • Medical practitioner credentialed in surgery available 24 hours (may include on-call).

[25] In line with Clinical Emergency Response Systems (CERS) for recognition of, and response to, paediatric clinical deterioration.

	• Medical practitioner available 24 hours for paediatric patients admitted overnight (may be on call). • Specialist surgical consultation available via networked arrangements (may be via virtual care). • Nursing – Refer to Appendix 1. • Access to allied health professionals, such as physiotherapist, occupational therapist, social worker, speech pathologist and dietitian (may include virtual care).
LEVEL 3 SURGERY FOR CHILDREN SERVICE – EXAMPLES OF ADDITIONAL SUPPORTED SERVICES	
Selected Minor and Common and Intermediate[27] surgical procedures for children aged 36 months or over with ASA level 3 risk completed with general anaesthesia[28]. Selected Major surgical procedures[19] for children aged 36 months or over with ASA category 1 and 2 risk completed with general anaesthesia[20].	

[27] Refer to Appendix 3 - Indicative list of surgery for children and Appendix 4 - Surgical complexity at each service capability level

[28] Refer to Appendix 2 - Levels of patient risk related to anaesthesia

7.4.3. Level 4 Surgery for Children service

LEVEL 4 SURGERY FOR CHILDREN SERVICE
SERVICE SCOPE

As for Level 3 and in addition **provides**:

- services for infants, children and adolescents above the age limit determined for the surgical specialty and hospital
- common and intermediate surgical procedures[29] for children aged 36 months or over with American Society of Anesthesiologists (ASA) level 1 to 3[30] risk or selected 4, completed with general anaesthesia - specific consideration related to credentialing and clinical privileges for <36 months
- major (selected) surgical procedures for children aged 36 months or over with ASA level 1 and 2 risk or selected 3, completed with general anaesthesia - specific consideration related to credentialing and clinical privileges for <36 months
- day-only and overnight admissions
- support for networked lower-level services within the local health district/ specialty health network including clinical advice and professional development support.

May provide:

- outreach to networked lower-level services within the local health district/ specialty health network including services, clinical advice and professional development support.

Capabilities	Resources
As for Level 3 and in addition: • more complex surgical procedures and anaesthesia for infants, children and adolescents at higher risk • escalates care to higher level service when additional care is required.	As for Level 3 and in addition: • Close observation service • Access to pathology and radiology under sedation or anaesthesia • access to ultrasound and Computed Tomography (CT) scanner[31] • access to electroencephalogram (EEG) (may be networked)[32].

[29] Refer Appendix 3 - Indicative list of surgery for children and Appendix 4 - Surgical complexity at each service capability level

[30] Refer Appendix 2 - Levels of patient risk related to anaesthesia

[31] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Radiology

[32] In line with *NSW Health Guide to the Role Delineation of Clinical Services* (2021) Neurology

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	4	4	4	4	4	4	4

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Levels 2 and 3
Competence and credentialing	As for Levels 2 and 3
Quality and safety processes	As for Level 3 and in addition: • Participates in clinical safety and quality processes of lower-level sites in LHD.
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Levels 2 and 3
Education	As for Level 3 and in addition: • active program of undergraduate and postgraduate teaching.
WORKFORCE	
Workforce and consultation	As for Level 3 and in addition: • Surgeon credentialed to treat paediatric patients. • Anaesthetist credentialed to treat paediatric patients. • Paediatrician available 24 hours (May be on call. Working 1 in 4 roster or less frequently[33]). • Medical practitioner with at least 3+ postgraduate years of experience (preferably in paediatrics) on-site 24 hours. • Nursing – Refer to Appendix 1.

[33] Henry Review Recommendation 22: The on-call roster for a level 4 paediatric facility be no more onerous than 1 in 4.

	• Allied health professionals with specific paediatric caseload on-site (such as an occupational therapist, physiotherapist, speech pathologist, dietitian and social worker). • Access to orthoptics, orthotics and audiology services.

LEVEL 4 SURGERY FOR CHILDREN SERVICE – EXAMPLES OF ADDITIONAL SUPPORTED SERVICES
Selected Complex Major surgical procedures (refer Appendix 3) on ASA category 1 to 5 children (refer to Appendix 2). Anaesthesia for children <36 months of age.

7.4.4. Level 6 Surgery for Children service

LEVEL 6 SURGERY FOR CHILDREN SERVICE	
SERVICE SCOPE	
As for Level 4 and in addition **provides**: • comprehensive multidisciplinary care for neonates, infants, children and adolescents with complex conditions and comorbidities • Major and Complex Major surgical procedures[34] with general anaesthesia for children of any age with American Society of Anesthesiologists (ASA) level 1 to 5[35] risk, with credentialed clinicians working within their clinical privileges • paediatric surgical subspecialty services on-site for infants, children and adolescents • paediatric and neonatal anaesthesia • paediatric surgery subspecialty support to lower-level services including clinical advice and professional development • paediatric anaesthesia subspecialty support to lower-level services including clinical advice and professional development. Statewide and ACT reach. Interstate and international service provision by negotiation. **May provide**: • cardiac, spinal and major burns surgical services.	
Capabilities	**Resources**
As for Level 4 and in addition: • subspecialty Surgery for Children services.	As for Level 4 and in addition: • Paediatric Intensive Care Unit. • Co-located Neonatal Intensive Care Unit.

[34] Refer to Appendix 3 - Indicative list of surgery for children and Appendix 4 – Surgical complexity at each service capability level
[35] Refer to Appendix 2 - Levels of patient risk related to anaesthesia

MINIMUM CORE SERVICES (with capacity to treat children)							
As per *NSW Health Guide to the Role Delineation of Clinical Services* (2024)	Anaesthetics	Operating Suite	Intensive Care Service	Nuclear Medicine	Radiology	Pathology	Pharmacy
	6	6	6	6	6	6	6

CLINICAL GOVERNANCE	
Guiding documents for service provision	As for Levels 2, 3, 4
Competence and credentialing	As for Levels 2, 3, 4
Quality and safety processes	As for Level 4
SERVICE REQUIREMENTS	
Consultation, escalation and transfer	As for Levels 2, 3, 4
Education	As for Level 4
WORKFORCE	
Workforce and consultation	As for Level 4 and in addition: • Clinical head of paediatric surgery service. • Surgeon with specialty interest available 24 hours. • Paediatric anaesthetist available 24 hours. • Medical practitioner in surgery with 3+ postgraduate years of experience on call 24 hours • Medical practitioner in anaesthesia with 3+ postgraduate years of experience on call 24 hours. • Medical practitioner in paediatrics with 3+ postgraduate years of experience on-site 24 hours. • Medical practitioner in paediatric subspecialties with three or more postgraduate years of experience. • Nursing – Refer to Appendix 1. • Allied health professionals with skills in paediatric subspecialties.

8. Appendices

1. Appendix 1: Nursing workforce
2. Appendix 2: Levels of patient risk related to anaesthesia
3. Appendix 3: Indicative list of surgery for children
4. Appendix 4: Surgical complexity at each service capability level

8.1. Appendix 1: Nursing workforce[36]

This content is modified from the *NSW Health Guide to the Role Delineation of Clinical Services* (2021) [Appendix IV].

Nursing staffing of all clinical services must adhere to the provisions set out in the Public Health System (Nurses' and Midwives') State Award ('the Award') and in particular the staffing arrangements under clause 53 which includes specific arrangements for General inpatient wards and Perioperative Services (ACORN 2008).

The number and skill level of the nurses required to provide the day-to-day care should be based on the number and acuity of the patients within each ward, unit and department within a clinical service and, where relevant, adhere to the minimum Nursing Hours per Patient Day set out in the Award and ACORN 2008 standards for operating theatres.

Nurses must have the appropriate skills, experience and qualifications for the clinical environment where they provide patient care.

Clinical supervision

For every ward/ unit/ department that delivers nursing care there should be a Nursing Unit Manager. Some clinical areas may have a Nursing Unit Manager who manages more than one ward/ unit/ department depending on clinical activity and/ or complexity. Larger services may have a Nurse Manager in addition to, or in place of, the Nursing Unit Manager.

There may be exceptions to this, for example, where a nurse works in a multidisciplinary team.

There must be a nurse/ midwife with appropriate experience in the In Charge of Shift role when the Nursing/ Midwifery Unit Manager is not on duty.

Clinical education

All wards/ units/ departments must have access to clinical education. While this will be provided predominantly by Clinical Nurse Educators (CNE), clinical education may also be provided by a variety of other nursing roles including (but not limited to) Clinical Nurse Specialists Grade 1 and 2 (CNS 1 and 2), Clinical Nurse Consultants (CNC), Nurse Educators (NE), Nurse Practitioners (NP), Registered Nurses and Registered Midwives.

Clinical expertise

Specialised wards /units/ departments that deliver nursing care must have access to an identified expert nursing resource with a high-level skill set in the relevant clinical specialty. This role would be provided predominantly by a CNC, an NP or a CNS2.

Depending on the role delineation and level of clinical service provided, the support may be provided on-site, across the local health district/ specialty health network or via telehealth.

[36] Guidance is available for the nursing workforce on staffing arrangements for clinical services. The same guidance is not currently available for other professions.

8.2. Appendix 2: Levels of patient risk related to anaesthesia

8.2.1. American Society of Anesthesiologists (ASA) Levels

The content below that applies to infants, children and adolescents is derived from the American Society of Anesthesiologists (ASA) Physical Status Classification System.

The purpose of the system is to assess and communicate a patient's pre-anaesthesia medical co-morbidities. The classification system alone does not predict the perioperative risks, but used with other factors (such as type of surgery, frailty, level of deconditioning) and can be helpful in predicting perioperative risks.

The definitions and examples shown in the table below are only a guide.

ASA level	Description	Paediatric examples including but not limited to:
1	A normal healthy patient	Healthy (no acute or chronic disease), normal BMI percentile for age
2	A patient with mild systemic disease	Asymptomatic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent diabetes mellitus, abnormal body mass index (BMI) percentile for age, mild/ moderate obstructive sleep apnoea (OSA), oncologic state in remission, autism with mild limitations
3	A patient with severe systemic disease	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/ spinal cord malformation, symptomatic hydrocephalus, premature infant post-conceptional age (PCA) <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants <6 weeks of age.
4	A patient with severe systemic disease that is a constant threat to life	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state.
5	A moribund patient not expected to survive without the operation	Massive trauma, intracranial hemorrhage with mass effect, patient requiring extracorporeal membrane oxygenation (ECMO), respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/ system dysfunction.

8.2.2. Factors that increase risk

Common factors known to significantly increase mortality or morbidity related to anaesthesia as outlined in the Australian and New Zealand College of Anaesthetists (ANZCA) PG29(A)BP Guideline for the provision of anaesthesia care to children Background Paper 2020 are:

1. Patient age
    - High risk[37]: neonates, ex-premature infants, age <12 months
    - Medium risk: age 12-36 months
    - Low risk: age > 36 months.
2. ASA status
    - High risk: ASA 3-5
    - Medium risk: ASA 2 including respiratory risk factors such as recent upper respiratory tract infections (URTI)
    - Low risk: ASA 1.
3. Surgery
    - High risk: Cardiothoracic, neurosurgery, scoliosis surgery
    - Medium risk: Airway and dental surgery
    - Low risk: Peripheral, minor surgery
    - Emergency surgery is associated with increased risk.
4. Experience of the anaesthetist: The experience and volume of practice of the anaesthetist in paediatric anaesthesia is relevant, however evidence for absolute numbers is weak.

[37] For the purpose of this document low risk means a relative risk of 1 or less, medium risk 2-3 times that and high risk 4 times or greater than low risk.

8.3. Appendix 3: Indicative list of surgery for children

There is no widely accepted and validated system for classifying the physiological stressfulness of surgical procedures. The examples given below drawn from different specialties are intended to provide an indicative guide of complexity only and do not replace clinical judgement. The actual range of procedures that may be performed by individual practitioners will be determined through the process for credentialing and delineating clinical privileges (refer to NSW Health Policy Directive *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* [PD2019_056]).

Minor	Common and Intermediate	Major	Complex major
Drainage of abscess	Adenoidectomy ≥36 months	Adenoidectomy <36months	Cleft lip/ palate surgery
Insertion of grommets	Appendicectomy	Closure of colostomy	Herniotomy <12 months
Minor debridement	Closed reduction of fracture	Fixation of upper femoral slipped epiphysis	Laparoscopic procedures <5 years of age
Percutaneous wire removal	Diagnostic endoscopy	Foot surgery (such as tendon release or transfer, subtalar fusion)	Major reconstructive surgery (such as anorectoplasty, rectosigmoidectomy)
Skin biopsy	Herniotomy ≥36 months	Herniotomy 12–36 months	Neurosurgery
Skin lesion curettage and cautery	Laser skin surgery	Insertion of central line in first two years of life	Open heart surgery
Skin lesion excision	Removal of foreign body from the oesophagus	Open reduction of fracture	Organ transplant
Suture of laceration	Scrotal exploration for testicular torsion[38]	Operative reduction of intussusception	Pyeloplasty
Tooth extraction	Simple skin graft	Orchidopexy	Scoliosis surgery
	Skin excision with flap or graft closure	Repair of hypospadias	Splenectomy
	Superficial corneal foreign body removal	Squint surgery	Thoracotomy
	Tonsillectomy ≥36 months with mild to moderate Obstructive Sleep Apnoea	Therapeutic endoscopy	Ureteric reimplantation
		Tonsillectomy <36 months or with severe Obstructive Sleep Apnoea	

[38] In general all patients with suspected torsion of testis should be managed at the hospital of presentation ref: Royal Australasian College of Surgeons Acute scrotal pain and suspected testicular torsion guidelines 2018

8.4. Appendix 4: surgical complexity at each service capability level

The following matrix provides indicative examples of surgery commonly provided for infants, children and adolescents at the various Surgery for Children service capability levels. Variables considered are patient age, complexity of the surgery (Appendix 3), type of anaesthesia and ASA level (Appendix 2).

This table is only a guide. The actual range of procedures that may be performed by individual practitioners is determined through the process for credentialing and delineating clinical privileges (refer to NSW Health Policy Directive *Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists* [PD2019_056]).

Surgery for Children Service capability level	Age	Complexity	Indicative examples (only) of surgery for children	Type of anaesthesia	ASA level
2	Any age	Minor	Drainage of abscess, tooth extraction, suture of laceration	Local	1 and 2
	≥36 months	Minor	Drainage of abscess, tooth extraction, suture of laceration	Local with conscious sedation	1 and 2
3	≥36 months (specific consideration related to credentialing and scope of practice for <36 months)	Minor	Drainage of abscess, tooth extraction, suture of laceration	Local with conscious sedation	1 to 3
		Minor and Common and Intermediate	Closed reduction of fracture, Appendicectomy and Tonsillectomy ≥36 months[39]	General	1 and 2
4	≥36 months (specific consideration related to credentialing and scope of practice for <36 months)	Common and Intermediate	Closed reduction of fracture, Appendicectomy, Tonsillectomy ≥36 months	General	1 to 3 and selected 4
		Major (selected)	Open reduction of fracture, Tonsillectomy <36 months, herniotomy 12–36	General	1, 2 and selected 3

[39] For Level 3 services providing additional supported services

Surgery for Children Service capability level	Age	Complexity	Indicative examples (only) of surgery for children	Type of anaesthesia	ASA level
			months, orchidopexy		
6	Any age with credentialed clinicians working within their scope of practice	Major	Open reduction of fracture, Tonsillectomy <36 months, herniotomy 12–36 months, orchidopexy	General	1 to 5
		Complex Major	Neurosurgery, cleft lip palate surgery, open heart surgery, scoliosis surgery	General	1 to 5