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Children with Life-Limiting Conditions in Paediatric Intensive Care Units: a national cohort, data linkage study

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Short Running Title: Children with life-limiting conditions in PICU

**What is known:** The prevalence of children and young people with a life-limiting (LLC) or life-threatening conditions (LTC) is rising. Overall mortality in PICU is decreasing.

**What this study adds:**

Children with a LLC accounted for the majority of admissions, bed-days and deaths in PICU. They were 75% more likely to die in PICU and there was 93% survival at one year for children with a LLC.

## **Abstract**

### *Objective*

To determine how many children are admitted to paediatric intensive care (PICU) with life-limiting conditions (LLC) and their outcomes.

### *Design*

National cohort , data-linkage study

### *Setting*

PICUs in England

### *Patients*

Children admitted to a UK PICU (1<sup>st</sup> Jan 2004 and 31<sup>st</sup> March 2015) were identified in the Paediatric Intensive Care Audit Network dataset. Linkage to hospital episodes statistics enabled identification of children with a LLC using an International Classification of Diseases (ICD10) codelist.

### *Main Outcome Measures*

Random effects logistic regression was undertaken to assess risk of death in PICU. Flexible parametric survival modelling was used to assess survival in the year after discharge.

### *Results*

Overall 57.6% (n=89,127) of PICU admissions and 72.90% (n=4821) of deaths in PICU were for an individual with a LLC.

The crude mortality rate in PICU was 5.4% for those with a LLC and 2.7% of those without a LLC. In the fully adjusted model, children with a LLC were 75% more likely than those without a LLC to die in PICU (OR 1.75 (95%CI 1.64-1.87)).

Although overall survival to one year post discharge was 96%, children with a LLC were 2.5 times more likely to die in that year than children without a LLC (OR 2.59 (95%CI 2.47-2.71)).

### *Conclusions*

Children with a LLC accounted for a large proportion of the PICU population. There is an opportunity to integrate specialist paediatric palliative care services with paediatric critical care to enable choice around place of care for these children and families.

## **Introduction**

Life-limiting conditions (LLC) are those for which there is no reasonable hope of cure and from which children will ultimately die, e.g. Duchenne Muscular Dystrophy or neurodegenerative disease. Life-threatening conditions (LTC) are those for which curative treatment may be feasible but can fail, e.g. cancer. LLC will be used to include life-limiting and life-threatening conditions.

The prevalence of children and young people (CYP) with a LLC is increasing [1] partly due to more aggressive treatment of complications and the use of medical technologies, including Paediatric Intensive Care (PICU). These children often have repeated hospital admissions [2] and use increasing amounts of hospital resources [3-5]. Many of these children also die on PICU [6] when treatment fails or is withdrawn. This study aims to ascertain what proportion of admissions to PICUs are for children with a LLC and their outcomes in PICU and up to one year post discharge.

## **Methods**

### *Datasets*

The Paediatric Intensive Care Audit Network (PICANet) collects data on all children admitted to PICUs in the UK and Ireland. All admissions to a PICU in the UK between 1/1/2004 and 31/3/2015 were identified in the PICANet dataset [7]. Only children resident in England were included as only their inpatient hospital data (Hospital Episodes Statistics (HES)) were available for linkage [8]. Hospital data for the other nations of the UK were not available.

The Office for National Statistics (ONS) death record data in England were available with a censor date of 1/11/2015 [9].

Linkage of the PICANet dataset to the HES and ONS data was undertaken by the NHS Digital [10]. The standard deterministic linkage algorithm using NHS number, date of birth, sex and postcode were used.

### *Clinical variables*

### Inpatient HES data

The PICANet data is of high quality and validated but some of the non-mandatory fields, including co-morbidities, are incomplete. Therefore it is not possible to identify children with a LLC using the PICANet dataset alone. Linkage to the inpatient HES data (1/4/1997-31/3/2015) enabled the use of a previously developed International Classification of Diseases (ICD10) coding framework [1] to identify individuals with a LLC (Supplementary Table 1). A PICU admission was categorised with a LLC if one of the LLC codes were recorded within the HES data for that individual before the date of PICU discharge. For the analyses for survival in the year after PICU discharge LLC codes up to the censor date were included.

### PICANet data

Clinical diagnoses were coded using Clinical Terms 3 and aggregated into 12 primary diagnostic groups [11].

Risk adjustment for mortality used the log odds of mortality based on the Paediatric Index of Mortality (PIM2) with recalibrated coefficients calculated using data from 2011-13 [12]. PIM2 was categorised into five categories of risk <1%, 1-<5%, 5-<15%, 15-<30%, 30%+.

Length of stay was categorised into <1 day, 1-< 3 days, 3-<7 days, 7-<14 days, 14-<28 days and  $\geq 28$  days. The total number of bed-days for each individual was calculated for all their PICU admissions. The number of PICU admissions were categorised as single admission, two admissions, three admissions, four or more admissions.

The type of admission was defined as planned after surgery, unplanned after surgery, planned other and unplanned.

### ONS Death Data

Date of death was obtained from the ONS data [9].

### *Socio-demographic variables*

Age at admission to PICU was categorized as <1 year, 1–4 years, 5–10 years, 11–15 years, ≥16 years.

Sex was included in the analysis only where it was non-ambiguous.

An Index of Multiple Deprivation (IMD)[13] category was assigned to each individual based upon their Lower Super Output Area (LSOA) of residence. An LSOA is a census geographical area built up of Output Areas with population of 1000–3000 per LSOA [14].

Ethnicity is poorly recorded in all the datasets therefore ethnicity was determined using two name analysis programs which classified children as South Asian (Pakistani, Indian, Bangladeshi): Nam Pehchan [15, 16] and the South Asian Names and Group Recognition Algorithm [17]. The results were corrected manually for known misclassification errors [18]. Ethnicity was assessed as South Asian or not as the South Asian population are the largest minority ethnic group in the UK(REF).

### *Statistical Analyses*

Descriptive statistics were undertaken and differences between groups assessed by chi-squared or t-test.

Random effects logistic regression was undertaken to account for inter PICU variation in the outcome; death in PICU. Variables were included via a forced entry method and retained if  $p < 0.05$  or if they improved the model fit assessed using the Bayesian information criterion (BIC).

Flexible parametric survival modelling was undertaken to assess survival in the year after discharge from PICU rather than traditional cox regression as the proportional hazards assumption was violated [19]. Data from the last PICU admission for each individual discharged alive from PICU were included.

Analyses were carried out using STATA version 13, and tests of statistical significance were at  $p \leq 0.05$ .

### *Ethics approval*

Collection of personally identifiable data has been approved by the Patient Information Advisory Group (now the Health Research Authority Confidentiality Advisory Group) see -

<http://www.hra.nhs.uk/documents/2015/12/piag-register-8.xls> - and ethics approval granted by the Trent Medical Research Ethics Committee, ref. 05/MRE04/17 +5.

## Results

### *Cohort and Linkage*

Nearly 200,000 PICU admissions occurred in the UK in the study period. After excluding non-English residents and those with poor quality demographic data<sup>1</sup>, data for 103,374 individuals were sent for linkage. Linkage was successful for 102,722 individuals (99%) who had 154,667 PICU admissions (Figure 1).

There were no significant differences between those who linked and those in whom linkage was not successful by sex, ethnicity, PIM2 score or length of PICU stay (Supplementary Table 2). Some significant differences were found; linkage improved from 98.0% in 2004 to 99.4% in 2015 (chi<sup>2</sup> 365,  $p < 0.001$ ), fewer >16 year olds linked compared to the < 1 year olds (98.9% vs 99.3%) and children with more PICU admissions were more likely to be linked than those with a single admission (99.5% vs 98.9% chi<sup>2</sup> 120,  $p < 0.001$ ).

### *Descriptive Statistics*

Overall 57.6% (n=89127) of PICU admissions were for an individual with a LLC (Table 1). Excluding 2015 data which is only part year, the percentage of admissions to PICU for those with a LLC has increased from 51.8% to 61.0%. There was a U shaped association with age with 58.5% of the under 1 year olds admitted to PICU having a LLC, 50.2% of the 11-15 year olds and 65.4% of the >16 year olds. More of the admissions from children with a South Asian background had a LLC compared to non-South Asians (62.9% vs 56.9% chi<sup>2</sup>=233,  $p < 0.001$ ).

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<sup>1</sup> Poor quality demographic data = missing NHS number and date of birth which are required for linkage



Differences between the two groups existed for the clinical variables with 94.1% of those children whose reason for PICU admission was multisystem having a LLC compared with only 8.8% of trauma cases and 43.3% of infective cases (chi2 1300, p<0.001).

The risk of mortality scores varied by LLC status with. 52.3% of those with a PIM 2 score <1% had a LLC, 77.8% of those with a PIM 2 score of 15-<30% and 62.3% of those with a PIM 2 score of >30% (chi2 2300, p<0.001).

A linear association with length of PICU stay was shown with 49.6% of those with a PICU stay of <1 day and 87.5% of those staying in PICU >28 days having a LLC (chi2 6000, p<0.001). The median length of stay was 2.6 days (IQR 1.0,6.1) for those with a LLC compared to 1.6 days (IQR 0.8,3.5) for those without a LLC.

The total number of PICU bed days for this cohort was 763,664; children with a LLC accounted for 72.6% (554,404).

More than 66% of the planned PICU admissions after surgery were for children with a LLC compared to 51.6% of unplanned PICU admissions (chi2 3600, p<0.001).

### *Deaths*

11,588 children had died at the censor date, with 6612 deaths occurring in PICU. Children with a LLC accounted for 72.9% (n=4821) of PICU deaths and 87.4% (n= 4397) of deaths after discharge. The crude PICU mortality rate was 5.4% for those with a LLC and 2.7% for those without a LLC.

### *Death in PICU*

The unadjusted risk of death in PICU for children with a LLC was nearly twice that of those without a LLC (OR 1.94 (95%CI 1.84,2.06)). After adjusting for expected risk of mortality and other clinical and demographic variables, children with a LLC were 75% more likely than those without a LLC to die in PICU (OR 1.75 (95%CI 1.64-1.87))(Table 2).

Stratified analyses by LLC status highlighted some differences between the main variables associated with a higher risk of death in PICU (Supplementary Table 3a and 3b). For those with a LLC, being older than age 16 years (OR 1.37 (95%CI 1.12-1.67)) and of South Asian origin (OR 1.30 (95%CI 1.20-1.41)) had a higher risk of death. This was not seen for those without a LLC. The diagnoses with highest risk of death in PICU were blood and lymph (OR 2.54 (95%CI 1.98-3.25)) or endocrine/metabolic (OR 2.38 (95%CI 2.05-2.76)) for those with a LLC compared to trauma (OR 2.37 (95%CI 1.84-3.00)) or neurological conditions (OR 2.19 (95%CI 1.79-2.69)) for those without a LLC. The risk of death was highest for stays longer than 7 days in those with a LLC but not until 14 days for those without a LLC.

The odds of dying in PICU decreased by 3% each year (OR 0.98 (95%CI 0.97-0.99)).

#### *Survival after discharge from PICU*

Overall survival rate is >96% at one year after PICU (figure 2a). There are differences between these survival functions for children with (Figure 2b) and without a LLC (Figure 2c). There is a steeper curve in the first 3 months after discharge from PICU for those with a LLC with approx. 93% still alive at one year post discharge. For those without a LLC the survival curve is much flatter and > 99% are alive at one year post PICU discharge.

A lognormal distribution model with 5 degrees of freedom provided the best fit assessed using BIC (Table 3). There are some similarities to the death in PICU model: children with a LLC ((OR 2.59 (95%CI 2.47-2.71)), those from a South Asian background (OR 1.19 (95%CI 1.13-1.25)) and those from the most deprived category (OR 1.08 (95%CI 1.02-1.14)) were more likely to die in the year after discharge from PICU than children without a LLC, non South-Asian and those in the least deprived areas respectively. All other types of PICU admission had significantly higher odds of death compared to the planned after surgery group and the odds of dying after discharge decreased by 3% with each increasing year of admission (OR 0.97 (95%CI 0.96-0.98)). Compared to the reference

group of respiratory reasons for PICU admission, those with an oncology (OR 1.83 (95%CI 1.70-1.97)) or neurology diagnoses (OR 1.17 (95%CI 1.11-1.24)) were more likely to die in the year after discharge from PICU. Those with trauma (OR 0.63 (95%CI 0.53-0.77)), or body wall and cavities (OR 0.63 (95%CI 0.54-0.72)) diagnoses were significantly less likely to die in the year after discharge from PICU.

In contrast to the in-PICU death models, all those aged 1- 15 years were significantly less likely to die than the <1 age group.

## **Discussion**

Children with a LLC accounted for nearly 58% of all admissions to PICU, 72% of PICU bed-days and 87.5% of all PICU admissions that lasted > 28 days. Although the mortality rate continues to decrease in PICU, 73% of all deaths in PICU during this study were in children with a LLC. The survival in the year after PICU discharge was also significantly lower in children with a LLC compared to those without a LLC.

The high number and percentage of PICU admissions for children with a LLC is similar to results from a US study in which children with complex chronic conditions (CCC) accounted for 53% (range 22.4-70.6%) of PICU admissions [20]. The definitions used to identify the populations with CCC were different to the LLC definition used in the current study. A multi country prevalence study found that 67% of children had a CCC or disability within PICU or NICU [21].

Previous work has found that children with a CCC had an increased risk of prolonged length of PICU stay (>15 days) [20] and children who died in PICU have longer lengths of stay before death [22]. This study has shown that the risk of death in PICU is significantly higher for those with a LLC who have been in PICU for longer than 7 days.

The higher PICU crude death rate for children with a LLC is not unexpected and confirms the patterns seen in the US study where they found in-PICU mortality of 3.9% for those with a CCC

compared to 2.2% for children with no chronic condition and 0.3% for those with non-complex chronic conditions [20]. However, death in a child with a LLC may be expected and admissions to PICU are known to be stressful [23-26] and parents and siblings of children who died in hospital show more psychological symptoms [27] and poorer adjustment [28] than if their child had died at home. If the child is likely to die despite PICU admission then an alternative place of care such as being cared for at home or in a hospice by specialist paediatric palliative care may be more appropriate. Guidance from The European Association of Palliative Care [29] and the International Children's Palliative Care Network [30] both state that the family home should, where possible, be the main place of care and that these families should have access to paediatric palliative care services.

With in-PICU mortality falling to low levels it is important that other in/post PICU outcomes such as quality of life or functional status are assessed, especially for this group of children with high care needs.

Although the vast majority of children survived their PICU admission, nearly 7% of those with a LLC will die in the year after discharge from PICU with many of these deaths occurring in the first 3 months. PICU staff are highly experienced at caring for a dying child and their family but given the expansion of specialist paediatric palliative care services and the children's hospice sector over the last decade further integration of these services may offer the family more choice over place of care or death for their child and can often offer longer term input, both when the child has died and in the bereavement period than is possible from a PICU.

### *Strengths/Limitations*

This is the first national study providing data on survival following PICU admission in this population of children and it utilised linked audit, administrative and hospital data. Identification of children with a LLC in this dataset was via the HES data. This is an administrative dataset in which the coding

has improved over time but its primary aim is not as a research dataset. Lack of agreement on definitions of some complex conditions has been shown previously [31]. Having complete data for co-morbidities in the PICANet dataset, which is audited for quality, would be preferable.

## **Conclusions**

Children with a LLC accounted for nearly 58% of admissions to PICU, 72% of bed-days, 87.5% of stays greater than 28 days and 73% of deaths in PICU. There is an opportunity, given the recent growth in specialist paediatric palliative care services, to have integration of these services to enable choice around place of care and place of death for these children and families.

Future studies collecting high quality information on changes in functional status and quality of life is vital to further gauge the clinical value of these PICU admissions.

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## **Conflicts of Interest Statement**

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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## References

1. Fraser LK, Miller M, Hain R, Norman P, Aldridge J, McKinney PA, Parslow RC, (2012) Rising National Prevalence of Life-Limiting Conditions in Children in England. *Pediatrics* 129: E923-E929
2. Benini F, Trapanotto M, Spizzichino M, Lispi L, dalla Pozza LV, Ferrante A, (2010) Hospitalization in Children Eligible for Palliative Care. *Journal of Palliative Medicine* 13: 711-717
3. Burns KH, Casey PH, Lyle RE, Mac Bird T, Fussell JJ, Robbins JM, (2010) Increasing Prevalence of Medically Complex Children in US Hospitals. *Pediatrics* 126: 638-646
4. Simon TD, Berry J, Feudtner C, Stone BL, Sheng X, Bratton SL, Dean JM, Srivastava R, (2010) Children With Complex Chronic Conditions in Inpatient Hospital Settings in the United States. *Pediatrics* 126: 647-655
5. Cohen E, Berry JG, Camacho X, Anderson G, Wodchis W, Guttman A, (2012) Patterns and Costs of Health Care Use of Children With Medical Complexity. *Pediatrics* 130: E1463-E1470
6. Ramnarayan P, Craig F, Petros A, Pierce C, (2007) Characteristics of deaths occurring in hospitalised children: Changing trends. *Journal of Medical Ethics* 33: 255-260
7. Paediatric Intensive Care Audit (2015) <http://www.picanet.org.uk>
8. NHS Digital (2016) NHS Digital Hospital Episodes Statistics. <http://content.digital.nhs.uk/hes>
9. Office for National Statistics (2014) Mortality Statistics: Deaths Registered in England and Wales by Area of Usual Residence, 2012. <http://www.ons.gov.uk/ons/publications/reference-tables.html?edition=tcm%3A77-332351>
10. NHS Digital (2016). Data Linkage [http://content.digital.nhs.uk/media/11668/HES-ONS-Mortality-Data-Guide/pdf/mortality\\_guide.pdf](http://content.digital.nhs.uk/media/11668/HES-ONS-Mortality-Data-Guide/pdf/mortality_guide.pdf)
11. PICANet (2014) PICANet Admission Dataset Definitions Manual Version 5.0. [http://www.picanet.org.uk/Documentation/Guidance/PICANet\\_Admission\\_Dataset\\_Manual\\_v5.0](http://www.picanet.org.uk/Documentation/Guidance/PICANet_Admission_Dataset_Manual_v5.0).
12. PICANet (2015) PICANet 2015 Annual Report. <http://www.picanet.org.uk/Audit/Annual-Reporting/>
13. Department for Communities and Local Government (2011) English indices of deprivation. <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010>
14. Public Health England (2013) IMD 2010 scores adjusted to align with 2011 LSOAs. <http://www.apho.org.uk/resource/item.aspx?RID=125887>
15. Bradford Health Authority and City of Bradford Metropolitan District Council (2002) Nam Pehchan computer program for the identification of names of south Asian ethnic origin.
16. Cummins C, Winter H, Cheng KK, Maric R, Silcocks P, Varghese C, (1999) An assessment of the Nam Pehchan computer program for the identification of names of south Asian ethnic origin. *Journal of Public Health Medicine* 21: 401-406
17. Nanchahal K, Mangtani P, Alston M, Silva ID, (2001) Development and validation of a computerized South Asian Names and Group Recognition Algorithm (SANGRA) for use in British health-related studies. *Journal of Public Health Medicine* 23: 278-285
18. Parslow RC, Tasker RC, Draper ES, Parry GJ, Jones S, Chater T, Thiru K, McKinney PA, Paediatric Intensive Care Audit N, (2009) Epidemiology of critically ill children in England and Wales: incidence, mortality, deprivation and ethnicity. *Archives of Disease in Childhood* 94: 210-215
19. Crowther MJ, Abrams KR, Lambert PC, (2012) Flexible parametric joint modelling of longitudinal and survival data. *Statistics in Medicine* 31: 4456-4471
20. Edwards JD, Houtrow AJ, Vasilevskis EE, Rehm RS, Markovitz BP, Graham RJ, Dudley RA, (2012) Chronic conditions among children admitted to U.S. pediatric intensive care units: their prevalence and impact on risk for mortality and prolonged length of stay. *Critical Care Medicine* 40: 2196-2203

21. Cremer R, Leclerc F, Lacroix J, Ploin D, (2009) Children with chronic conditions in pediatric intensive care units located in predominantly French-speaking regions: Prevalence and implications on rehabilitation care need and utilization. *Critical Care Medicine* 37: 1456-1462
22. Plunkett A, Parslow RC, (2016) Is it taking longer to die in paediatric intensive care in England and Wales? *Archives of Disease in Childhood*
23. Balluffi A, Dominguez TE, Tucker M, Kassam-Adams N, Kazak A, Helfaer MA, (2001) Post-traumatic stress responses of parents in the pediatric intensive care unit (PICU). *Critical Care Medicine* 29: A150-A150
24. Bronner MB, Knoester H, Bos AP, Last BF, Grootenhuis MA, (2008) Follow-up after paediatric intensive care treatment: parental posttraumatic stress. *Acta Paediatrica* 97: 181-186
25. Colville G, Darkins J, Hesketh J, Bennett V, Alcock J, Noyes J, (2009) The impact on parents of a child's admission to intensive care: Integration of qualitative findings from a cross-sectional study. *Intensive and Critical Care Nursing* 25: 72-79
26. Mortensen J, Simonsen BO, Eriksen SB, Skovby P, Dall R, Elklit A, (2015) Family-centred care and traumatic symptoms in parents of children admitted to PICU. *Scandinavian Journal of Caring Sciences* 29: 495-500
27. Mulhern RK, Lauer ME, Hoffmann RG, (1983) Death of a child at home or in the hospital - subsequent psychological adjustment of the family. *Pediatrics* 71: 743-747
28. Lauer ME, Mulhern RK, Wallskog JM, Camitta BM, (1983) A comparison study of parental adaptation following a child's death at home or in the hospital. *Pediatrics* 71: 107-112
29. Craig F, Huijter HA-S, Benini F, Kuttner L, Wood C, Feraris PC, Zernikow B, (2008) IMPaCCT: standards of paediatric palliative care. *Schmerz* 22: 401-408
30. International Children's Palliative Care Network (2008) ICPCN Charter for the Rights of Life-Limited and Life-Threatened Children and Young People. [www.icpcn.org.uk](http://www.icpcn.org.uk)
31. Pearson GA, Ward-Platt M, Kelly D (2011) How children die: classifying child deaths  
*Archives of Disease in Childhood* 2011;**96**:922-926.



Table 1 Descriptive Statistics of PICU Admissions by LLC Status (with row %)

	Total	LLC		No LLC		$\chi^2$	P value
<b>Number</b>	154,667	89127	57.6	65540	42.4		
<b>Age Category</b>						556	<0.001
<1 year	72,170	42,232	58.5	29,938	41.5		
1-4 years	39,571	23,097	58.4	16,474	41.6		
5-10 years	20,448	11,982	58.6	8,466	41.4		
11-15 years	19,003	9,542	50.2	9,461	49.8		
16+	3,467	2,267	65.4	1,200	34.6		
missing	8	7		1			
<b>Sex</b>						3.1	0.21
Male	87,686	50,422	57.5	37,264	42.5		
Female	66,933	38,682	57.8	28,251	42.2		
missing	48	23		25			
<b>Ethnicity</b>						233	<0.001
Non South Asian	136,670	77,804	56.9	58,866	43.1		
South Asian	17,997	11,323	62.9	6,674	37.1		
<b>Deprivation Category</b>						74.7	<0.001
Category 1 (least deprived)	21,421	12,101	56.5	9,320	43.5		
Category 2	21,816	12,573	57.6	9,243	42.4		
Category 3	26,341	15,437	58.6	10,904	41.4		
Category 4	34,498	19,935	57.8	14,563	42.2		
Category 5 (most deprived)	49,538	28,361	57.3	21,177	42.7		
missing	1,053	720		333			
<b>Diagnostic Group (reason for PICU admission)</b>						1300	<0.001
Neurological	17,270	8,154	47.2	9,116	52.8		
Cardiac	44,767	32,465	72.5	12,302	27.5		
Respiratory	42,230	21,687	51.4	20,543	48.6		
Oncology	5,190	4,663	89.8	527	10.2		
Infection	8,014	3,468	43.3	4,546	56.7		
Musculoskeletal	5,736	3,192	55.6	2,544	44.4		
Gastrointestinal	10,019	5,245	52.4	4,774	47.6		
Other	8,140	4,554	55.9	3,586	44.1		
Blood and lymph	1,456	757	52.0	699	48.0		
Trauma	4,581	405	8.8	4,176	91.2		
Endocrine/metabolic	3,878	2,131	55.0	1,747	45.0		
Multisystem	427	402	94.1	25	5.9		
Body wall and cavities	2,959			808			
		2,004	67.7		32.3		
<b>Risk of Mortality (PIM 2)</b>						2001	<0.001
<1%	48,957	25,583	52.3	23,374	47.7		
1-<5%	74,212	42,403	57.1	31,809	42.9		
5-<15%	24,727	16,261	65.8	8,466	34.2		
15-<30%	4,270	3,321	77.8	949	22.2		
>30%	2,501	1,559	62.3	942	37.7		
<b>LOS PICU (days)</b>						5600	<0.001
<1	45,246	22,420	49.6	22,826	50.4		
1 to <3	49,285	26,579	53.9	22,706	46.1		
3 to <7	34,122	20,381	59.7	13,741	40.3		

7 to <14	15,957	11,342	71.1	4,615	28.9		
14 to <28	6,603	5,401	81.8	1,202	18.2		
28+	3,412	2,986	87.5	426	12.5		
missing	42	18	42.9	24	57.1		
<b>Type of PICU admission</b>						3600	<0.001
Planned - after surgery	49,749	33,034	66.4	16,715	33.6		
Unplanned after surgery	7,688	3,985	51.8	3,703	48.2		
Planned other	10,900	7,551	69.3	3,349	30.7		
Unplanned	86,050	44,412	51.6	41,638	48.4		
Not known	280	145		135			
<b>Year of PICU admission</b>						574	<0.001
2004	12,293	6,366	51.8	5,927	48.2		
2005	12,326	6,531	53.0	5,795	47.0		
2006	12,634	7,116	56.3	5,518	43.7		
2007	13,275	7,492	56.4	5,783	43.6		
2008	13,462	7,463	55.4	5,999	44.6		
2009	14,023	7,994	57.0	6,029	43.0		
2010	14,185	8,341	58.8	5,844	41.2		
2011	14,006	8,282	59.1	5,724	40.9		
2012	14,597	8,904	61.0	5,693	39.0		
2013	14,865	9,126	61.4	5,739	38.6		
2014	14,973	9,137	61.0	5,836	39.0		
2015	4,028	2,375	59.0	1,653	41.0		

Table 2 Random Effects Logistic Regression Model for Death in PICU

[n=153,513, group = 35, wald chi2=10213, BIC= 40229, sigma\_u=0.30, rho=0.03]

	Odds Ratio	95% Confidence Intervals		p-value
<b>LLC</b>				
No	REF			
Yes	1.75	1.64	1.87	<0.001
<b>Age Category</b>				
<1 year	REF			
1-4 years	0.81	0.75	0.87	<0.001
5-10 years	0.94	0.86	1.03	0.20
11-15 years	1.06	0.96	1.16	0.26
16+	1.37	1.13	1.66	<0.001
<b>Sex</b>				
Male	REF			
Female	1.09	1.03	1.15	0.002
<b>Ethnicity</b>				
Non South Asian	REF			
South Asian	1.30	1.20	1.41	<0.001
<b>Deprivation Category</b>				
Category 1 (least deprived)	REF			
Category 2	1.02	0.91	1.13	0.77
Category 3	1.03	0.92	1.14	0.64
Category 4	1.07	0.97	1.18	0.18
Category 5 (most deprived)	1.07	0.97	1.17	0.17
<b>Diagnostic Group (reason for PICU admission)</b>				
Neurological	1.39	1.26	1.54	<0.001
Cardiac	1.23	1.13	1.35	0.001
Respiratory	REF			
Oncology	2.06	1.75	2.42	<0.001
Infection	1.94	1.74	2.17	<0.001
Musculoskeletal	0.74	0.55	0.99	0.04
Gastrointestinal	1.39	1.22	1.58	<0.001
Other	1.26	1.10	1.45	<0.001
Blood and lymph	2.32	1.86	2.91	<0.001
Trauma	1.69	1.43	2.01	<0.001
Endocrine/metabolic	2.18	1.90	2.50	<0.001
Multisystem	0.67	0.33	1.38	0.28
Body wall and cavities	0.97	0.76	1.22	0.78
<b>Risk of Mortality (PIM 2)</b>				
<1%	REF			
1-<5%	4.54	3.91	5.28	<0.001
5-<15%	12.46	10.65	14.57	<0.001
15-<30%	32.56	27.44	38.64	<0.001
>30%	201.63	169.60	239.70	<0.001
<b>LOS PICU (days)</b>				
<1	1.51	1.39	1.63	<0.001
1 to <3	REF			

3 to <7	0.86	0.79	0.94	0.001
7 to <14	1.09	0.99	1.20	0.07
14 to <28	2.02	1.81	2.24	<0.001
>28	3.98	3.53	4.47	<0.001
<b>Type of PICU admission</b>				
Planned - after surgery	REF			
Unplanned after surgery	1.20	1.01	1.42	0.04
Planned other	1.32	1.14	1.52	<0.001
Unplanned	1.53	1.38	1.70	<0.001
Not known	1.35	0.63	2.88	0.44
<b>Year of Admission</b>	0.97	0.96	0.98	<0.001

Table 3 Results of Flexible parametric survival modelling for survival to 365 days after discharge from PICU

[n=91,614]

	Hazard Ratio	95% Confidence Intervals		p-value
<b>Age Category</b>				
<1 year	REF			
1-4 years	0.83	0.80	0.87	<0.001
5-10 years	0.77	0.73	0.82	<0.001
11-15 years	0.85	0.80	0.90	<0.001
16+	0.98	0.89	1.09	0.72
<b>Sex</b>				
Male	REF			
Female	1.02	0.99	1.06	0.23
<b>Ethnicity</b>				
Non South Asian	REF			
South Asian	1.19	1.13	1.25	<0.001
<b>Deprivation Category</b>				
Category 1 (least deprived)	REF			
Category 2	0.99	0.92	1.05	0.66
Category 3	1.03	0.96	1.09	0.41
Category 4	1.06	1.00	1.13	0.04
Category 5 (most deprived)	1.08	1.02	1.14	0.01
<b>LLC</b>				
No	REF			
Yes	2.59	2.47	2.71	<0.001
<b>Diagnostic Group (reason for PICU admission)</b>				
Neurological	1.17	1.11	1.24	<0.001
Cardiac	0.86	0.81	0.90	<0.001
Respiratory	REF			
Oncology	1.83	1.70	1.97	<0.001
Infection	0.87	0.80	0.94	0.001
Musculoskeletal	0.91	0.81	1.03	0.152
Gastrointestinal	1.04	0.97	1.12	0.276
Other	1.04	0.96	1.13	0.339
Blood and lymph	0.98	0.82	1.17	0.79
Trauma	0.63	0.53	0.77	<0.001
Endocrine/metabolic	1.08	0.98	1.20	0.117
Multisystem	0.97	0.70	1.33	0.831
Body wall and cavities	0.63	0.54	0.72	<0.001
<b>Risk of Mortality (PIM 2)</b>				
<1%	REF			
1-<5%	1.28	1.22	1.35	<0.001
5-<15%	1.55	1.45	1.64	<0.001
15-<30%	2.07	1.88	2.28	<0.001
>30%	2.46	2.12	2.85	<0.001
<b>LOS PICU (days)</b>				
<1	1.14	1.08	1.19	<0.001

1 to <3	REF			
3 to <7	1.06	1.01	1.12	0.01
7 to <14	1.29	1.22	1.37	<0.001
14 to <28	1.58	1.47	1.71	<0.001
>28	1.75	1.57	1.95	<0.001
<b>Type of PICU admission</b>				
Planned - after surgery	REF			
Unplanned after surgery	1.22	1.12	1.33	<0.001
Planned other	1.65	1.54	1.78	<0.001
Unplanned	1.37	1.29	1.44	<0.001
Not known	1.17	0.76	1.78	0.48
<b>Year of Admission</b>	0.97	0.96	0.98	<0.001

**Figure 1 Study Flowchart**

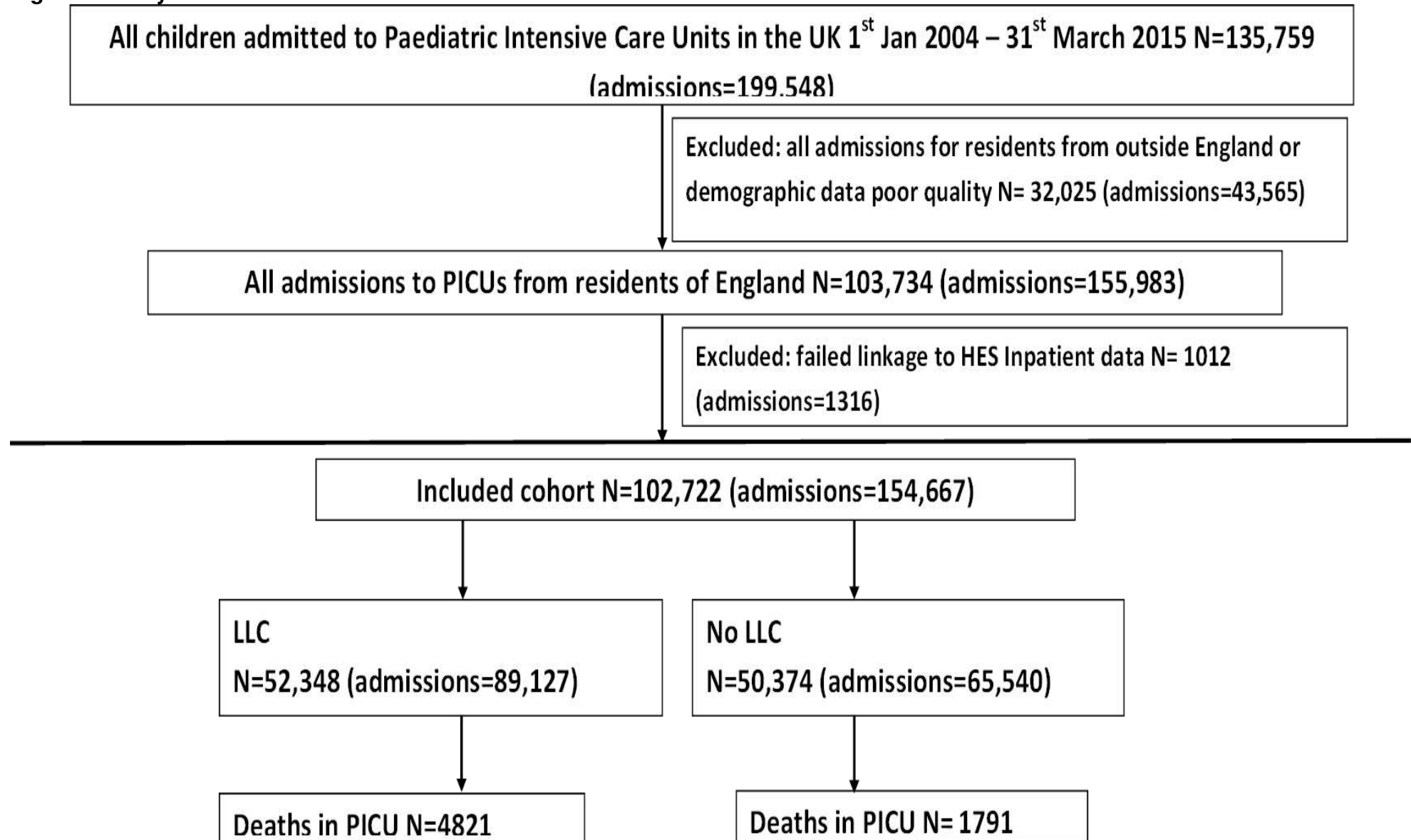


Figure 2 Survival Curves with 95% Confidence intervals

Figure 2a

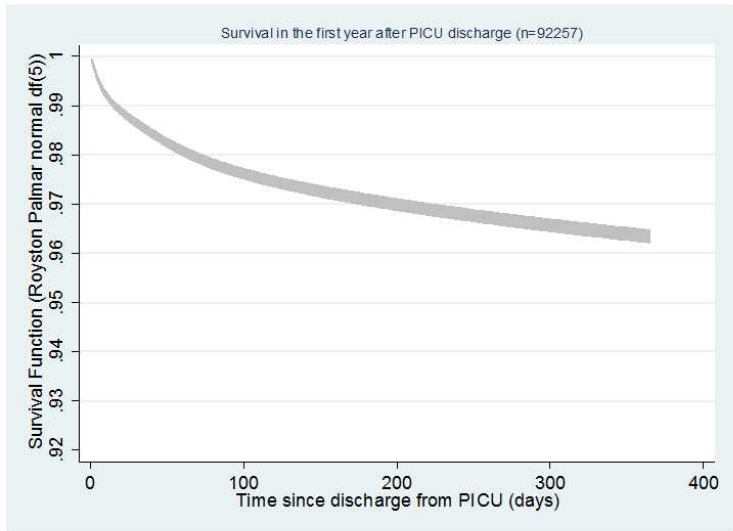


Figure 2c

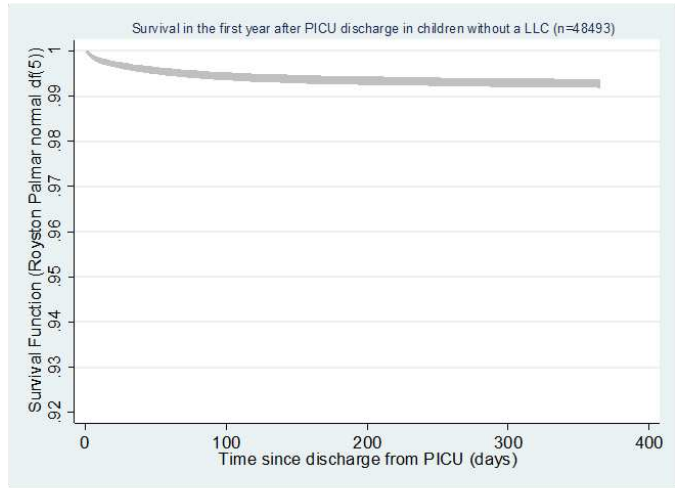
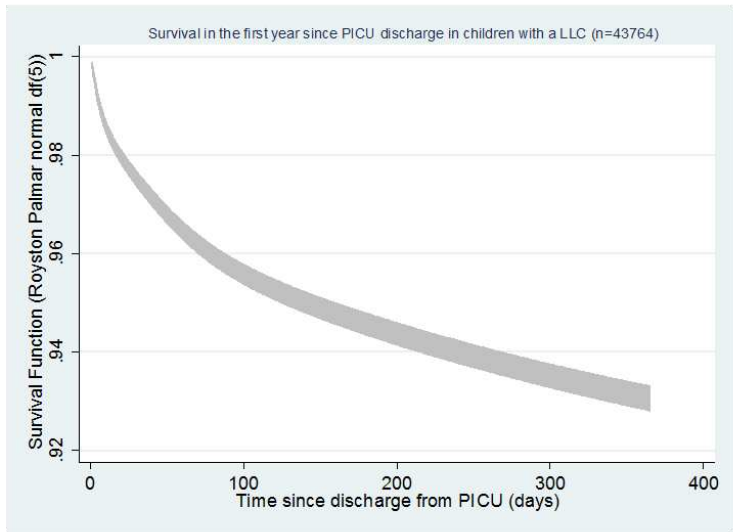


Figure 2b





Supplemental Table 1 ICD10 FILTER CODES to IDENTIFY LIFELIMITING DIAGNOSES IN CHILDREN & YOUNG PEOPLE

A	B	C	D	E	F	G	G	H	I	J
A17 A81.0 A81.1	B20-B24	C00-C97	D33 D43 D44.4 D48 D56.1 D61.0 D61.9 D70 D76.1 D81 D82.1 D83 D89.1	E31.0 E34.8 E70.2 E71 E72 E74 E75 E76 E77 E79.1 E83.0 E84 E88.0 E88.1	F80.3 F84.2	G10 G11.1 G11.3 G12 G20 G23.0 G23.8 G31.8 G31.9 G35 G40.4 G40.5 G60.0 G60.1 G70.2 G70.9 G71.0 G71.1 G71.2 G71.3 G80.0 G80.8	G82.3 G82.4 G82.5 G93.4 G93.6 G93.7	H11.1 H49.8 H35.5	I21 I27.0 I42 I61.3 I81	J84.1 J96 J98.4
K	L	N	P	Q	Q	Q	Q	Q	T	Z
K55.0 K55.9 K72 K74 K76.5 K86.8	M31.3 M32.1 M89.5	N17 N18 N19 N25.8	P10.1 P11.2 P21.0 P28.5 P29.0 P29.3 P35.0 P35.1 P35.8 P37.1	Q00.0 Q01 Q03.1 Q03.9 Q04.0 Q04.2 Q04.3 Q04.4 Q04.6 Q04.9	Q21.8 Q22.0 Q22.1 Q22.4 Q22.5 Q22.6 Q23.0 Q23.4 Q23.9 Q25.4	Q39.6 Q41.0 Q41.9 Q43.7 Q44.2 Q74.8 Q44.5 Q44.7 Q60.1 Q60.6	Q78.0 Q78.5 Q79.2 Q79.3 Q80.4 Q81 Q82.1 Q82.4 Q85.8 Q86.0	Q93.2 Q93.3 Q93.4 Q93.5 Q93.8 Q95.2	T86.0 T86.2	Z51.5

			P52.4	Q07.0	Q25.6	Q61.4	Q87.0			
			P52.5	Q20.0	Q26.2	Q61.9	Q87.1			
			P52.9	Q20.3	Q26.4	Q64.2	Q87.2			
			P83.2	Q20.4	Q26.8	Q74.3	Q87.8			
			P91.2	Q20.6	Q28.2	Q75.0	Q91			
			P91.6	Q20.8	Q32.1	Q77.2	Q92.0			
			P96.0	Q21.3	Q33.6	Q77.3	Q92.1			
				Q23.2		Q77.4	Q92.4			
							Q92.7			

Supplemental Table 2 Comparison of descriptive statistics between those PICU admissions which did and did not Link to the HES

	Linked		Linkage unsuccessful		$\chi^2$	P value
<b>Number</b>	154,667	99.2	1316	0.8		
<b>Age Category</b>					25.5	<0.001
<1 year	72,170	99.3	533	0.7		
1-4 years	39,571	99.1	347	0.9		
5-10 years	20,448	99.0	214	1.0		
11-15 years	19,003	99.0	184	1.0		
16+	3,467	98.9	38	1.1		
missing	8	100.0	0	0.0		
<b>Sex</b>					0.43	0.51
Male	87,686	99.2	726	0.8		
Female	66,933	99.1	575	0.9		
missing	48		15			
<b>Ethnicity</b>					2.6	0.10
Non South Asian	136,670	99.2	1,144	0.8		
South Asian	17,997	99.1	172	0.9		
<b>Deprivation Category</b>					148	<0.001
Category 1 (least deprived)	21,421	99.3	152	0.7		
Category 2	21,816	98.8	268	1.2		
Category 3	26,341	98.9	284	1.1		
Category 4	34,498	99.2	272	0.8		
Category 5 (most deprived)	49,538	99.5	230	0.5		
missing	1,053	90.5	110	9.5		
<b>Diagnostic Group (reason for PICU admission)</b>					184	<0.001
Neurological	17,270	99.0	181	1.0		
Cardiac	44,767	99.4	268	0.6		
Respiratory	42,230	99.3	279	0.7		
Oncology	5,190	98.4	84	1.6		
Infection	8,014	99.1	73	0.9		
Musculoskeletal	5,736	98.9	61	1.1		
Gastrointestinal	10,019	98.9	112	1.1		
Other	8,140	98.7	109	1.3		
Blood and lymph	1,456	98.3	25	1.7		
Trauma	4,581	98.3	77	1.7		
Endocrine/metabolic	3,878	99.2	32	0.8		
Multisystem	427	99.5	2	0.5		
Body wall and cavities						
	2,959	99.6	13	0.4		
<b>Risk of Mortality (PIM 2)</b>					8.8	0.07
<1%	48,957	99.2	415	0.8		
1-<5%	74,212	99.1	668	0.9		
5-<15%	24,727	99.3	185	0.7		
15-<30%	4,270	99.4	25	0.6		
>30%	2,501	99.1	23	0.9		
<b>LOS PICU (days)</b>					10.5	0.11
<1	45,246	99.1	426	0.9		
1 to <3	49,285	99.2	413	0.8		

3 to <7	34,122	99.2	273	0.8		
7 to <14	15,957	99.3	120	0.7		
14 to <28	6,603	99.3	48	0.7		
28+	3,412	99.0	36	1.0		
missing	42		0			
<b>Type of PICU admission</b>					45.5	<0.001
Planned - after surgery	49749	99.2	398	0.79		
Unplanned after surgery	7688	99.2	64	0.83		
Planned other	10900	98.6	155	1.40		
Unplanned	86050	99.2	696	0.80		
Not known	280		3			
<b>No. PICU admissions</b>					120	<0.001
one admission	77,426	98.9	837	1.1		
2 admissions	28,850	99.2	238	0.8		
3 admissions	15,726	99.4	90	0.6		
4+ admissions	32,665	99.5	151	0.5		
<b>Year of PICU admission</b>					365	<0.001
2004	12,293	98.0	245	2.0		
2005	12,326	98.5	193	1.5		
2006	12,634	98.8	150	1.2		
2007	13,275	99.4	84	0.6		
2008	13,462	99.5	68	0.5		
2009	14,023	99.3	100	0.7		
2010	14,185	99.3	102	0.7		
2011	14,006	99.4	90	0.6		
2012	14,597	99.2	111	0.8		
2013	14,865	99.6	57	0.4		
2014	14,973	99.4	90	0.6		
2015	4,028	99.4	26	0.6		

Supplemental Table 3a Random Effects Logistic Regression Model for Death in PICU (LLC only)

[n= 88,356, group = 35, wald chi2=5603, sigma\_u=0.21, rho=0.02]

	Odds Ratio	95% Confidence Intervals		p-value
<b>Age Category</b>				
<1 year	REF			
1-4 years	0.85	0.78	0.92	<0.001
5-10 years	0.93	0.84	1.03	0.17
11-15 years	1.03	0.92	1.15	0.66
16+	1.37	1.12	1.67	0.002
<b>Sex</b>				
Male	REF			
Female	1.11	1.04	1.18	0.001
<b>Ethnicity</b>				
Non South Asian	REF			
South Asian	1.30	1.20	1.41	<0.001
<b>Deprivation Category</b>				
Category 1 (least deprived)	REF			
Category 2	1.00	0.88	1.13	0.96
Category 3	1.02	0.90	1.14	0.80
Category 4	1.03	0.92	1.15	0.59
Category 5 (most deprived)	1.03	0.92	1.15	0.60
<b>Diagnostic Group (reason for PICU admission)</b>				
Neurological	1.10	0.97	1.24	0.141
Cardiac	1.16	1.05	1.28	0.003
Respiratory	REF			
Oncology	1.91	1.62	2.25	<0.001
Infection	2.06	1.82	2.35	<0.001
Musculoskeletal	0.74	0.54	1.00	0.05
Gastrointestinal	1.30	1.12	1.51	<0.001
Other	1.07	0.90	1.27	0.43
Blood and lymph	2.54	1.98	3.25	<0.001
Trauma	1.13	0.73	1.74	0.58
Endocrine/metabolic	2.38	2.05	2.76	<0.001
Multisystem	0.61	0.30	1.25	0.18
Body wall and cavities	0.91	0.70	1.17	0.45
<b>Risk of Mortality (PIM 2)</b>				
<1%	REF			
1-<5%	3.86	3.29	4.53	<0.001
5-<15%	8.62	7.28	10.21	<0.001
15-<30%	18.49	15.35	22.29	<0.001
>30%	76.18	62.76	92.48	<0.001
<b>LOS PICU (days)</b>				
<1	1.47	1.33	1.62	<0.001
1 to <3	REF			
3 to <7	0.90	0.81	0.99	0.03
7 to <14	1.16	1.04	1.29	0.01

14 to <28	2.12	1.89	2.37	<0.001
>28	3.96	3.50	4.49	<0.001
<b>Type of PICU admission</b>				
Planned - after surgery	REF			
Unplanned after surgery	1.19	0.98	1.45	0.07
Planned other	1.37	1.17	1.59	<0.001
Unplanned	1.64	1.47	1.83	<0.001
Not known	1.40	0.60	3.29	0.44
<b>Year of Admission</b>	0.97	0.96	0.98	<0.001

Supplemental Table 3b Random Effects Logistic Regression Model for Death in PICU (non LLC only)

[n= 65,132, group = 35, wald chi2=4148, sigma\_u=0.28, rho=0.02]

	Odds Ratio	95% Confidence Intervals		p-value
<b>Age Category</b>				
<1 year	REF			
1-4 years	0.66	0.56	0.77	<0.001
5-10 years	0.96	0.79	1.17	0.69
11-15 years	0.99	0.82	1.20	0.90
16+	1.08	0.60	1.92	0.80
<b>Sex</b>				
Male	REF			
Female	1.06	0.94	1.20	0.31
<b>Ethnicity</b>				
Non South Asian	REF			
South Asian	1.06	0.88	1.27	0.55
<b>Deprivation Category</b>				
Category 1 (least deprived)	REF			
Category 2	1.08	0.85	1.37	0.52
Category 3	1.02	0.81	1.28	0.88
Category 4	1.17	0.94	1.44	0.15
Category 5 (most deprived)	1.17	0.96	1.43	0.13
<b>Diagnostic Group (reason for PICU admission)</b>				
Neurological	2.19	1.79	2.69	<0.001
Cardiac	1.77	1.42	2.21	<0.001
Respiratory	REF			
Oncology	2.12	0.91	4.91	<0.001
Infection	2.05	1.63	2.58	<0.001
Musculoskeletal	0.71	0.24	2.11	0.08
Gastrointestinal	1.82	1.39	2.39	<0.001
Other	1.65	1.25	2.19	0.54
Blood and lymph	1.77	1.00	3.12	<0.001
Trauma	2.37	1.84	3.06	<0.001
Endocrine/metabolic	1.77	1.26	2.50	0.05
Multisystem	1.00			
Body wall and cavities	1.13	0.62	2.05	0.001
<b>Risk of Mortality (PIM 2)</b>				
<1%	REF			
1-<5%	7.14	4.56	11.18	<0.001
5-<15%	34.61	21.95	54.57	<0.001
15-<30%	183.20	113.88	294.69	<0.001
>30%	1530.22	954.72	2452.64	<0.001
<b>LOS PICU (days)</b>				
<1	1.66	1.43	1.93	<0.001
1 to <3	REF			
3 to <7	0.74	0.63	0.88	0.001
7 to <14	0.87	0.70	1.09	0.22
14 to <28	1.56	1.15	2.12	0.004

>28	4.07	2.75	6.02	<0.001
<b>Type of PICU admission</b>				
Planned - after surgery	REF			
Unplanned after surgery	2.04	1.36	3.08	0.001
Planned other	1.25	0.80	1.96	0.321
Unplanned	2.11	1.54	2.88	<0.001
Not known	1.83	0.32	10.33	0.494
<b>Year of Admission</b>	0.95	0.94	0.97	<0.001