1. Population Needs

1.1 National/Local Context and Evidence Base

- Paediatric Intensive Care Transport involves the transfer of critically ill children between hospitals. This is provided by specialist teams and the service does not respond to primary 999 calls.

- The transfer covers the pathway for a critically ill or injured child to a Paediatric Critical Care (PCC) Unit and referral may originate usually from a local general hospital in patient service or a specialist service (including PICUs) or an emergency department.

- Between 2008 and 2010 total retrievals to PICUs in England were recorded at 17,305 (PICANET Annual Report 2011). The current level of retrievals are recorded as circa 6000-7000 retrievals each year with an expectation that these numbers will rise as a result of the national reconfiguration of children’s cardiac surgery services (Safe and Sustainable).
• The definitions for this specification on Paediatric Intensive Care Transport Services are set out in the Department of Health’s ‘Paediatric Intensive Care, ‘A Framework for the Future’, report from the National Coordinating Group on Paediatric Intensive Care to the Chief Executive of the NHS Executive’, January 1997 (www.dh.gov.uk) and professional standards provided by the ‘Standards for the Care of Critically Ill Children’, 4th ed. June 2010 (UK Paediatric Intensive Care Society (PICS) www.ukpics.org.) The PICS document specifically sets out the standards for the retrieval and transfer of the most critically ill children.

• The publication of the ‘Framework for the Future’ report (1997) recommended that there should be centralised provision of Paediatric Intensive Care (PIC), supported by the development of networks linking the Lead PIC centre to local referring centres and specialist units. The requirement for dedicated Paediatric Intensive Care (PIC) Transport teams is also highlighted as essential in “Getting the right start: National Service Framework for Children ‘Standard for Hospital Services’ (2003).”

• The provision of centralised services necessitates the provision of transport services to move critically ill children between the local centre and the PICU.

• PIC Transport Services exist to support geographical equity in the provision of PCC services.

• The ‘Framework for the Future’ (1997) report indicated that; “A retrieval service should be funded and staffed on a 24 hour basis in each geographical area”.

2. Scope

2.1 Aims and Objectives of Service

PIC Transport Services exist to ensure that critically ill children have equitable access to timely, safe and clinically effective PCC provision wherever they present in a geographical area. These PCC facilities are centralised in a small number of hospitals providing expert specialist care and therefore specialist teams are required to deliver expert clinical management during transfer to optimise clinical outcomes from the point of contact with the transport team.
A PIC Transport Service shall be available 24 hours a day 365 days per year to transfer critically ill children from local referring centres to PCC units within the agreed catchment population.

- The Transport Service will operate without compromising the care of children on the PICU.
- Medical cover arrangements will be sufficient to ensure that where Consultant staff participate in the Transport Service, that they have no other clinical responsibilities. Additional Consultant staff must be available to PICU in the event of the Consultant attending a retrieval.

**Service Objectives**

- The PIC Transport Service must deliver the key objectives outlined below in order that the critically ill children referred have the best opportunity for improved morbidity and mortality and optimal quality outcomes.

- The Transport Service may be delivered by a PICU centre or a separate Transport Service. In either case the staffing will be dedicated to that Retrieval Service.

- The staffing of the team will allow the Transport Service to operate as a remote PICU bed in the management of critically ill children.

- The staffing will therefore be in addition to that required for a PICU and must have the ability to:
  - Retrieve at least 95% of children when retrieval is requested
  - Operate when there is no bed available on the local PICU
  - Demonstrate timely response times for retrieval
  - Retrieve critically ill children from within its regular catchment, and in exceptional circumstances from outside its regular catchment
  - Transfer children to PICUs within its regular catchment, and sometimes to PICUs outside its regular catchment

**Partnership Arrangements**

- To achieve optimum outcomes a Transport Service will work in partnership with the network, lead PICU and local referring centres to ensure that within the network the following functions are provided:
  - Support in the care of critically ill children including through advice, training and audit
• Resuscitation and stabilisation by local referring staff to agreed protocols
• Retrieval of stabilised children in an appropriately staffed and equipped mobile intensive care environment to a lead centre.

  o The Transport Service will work in an integrated and supportive way with other Transport Services.

**Relevant Patient Groups**

  o The Transport Service is expected to transport critically ill children.

  o Patients appropriate to receive treatment and transport by a PIC Transport Service will be expected to be any child requiring admission to PICU or centralised HDU.

  o National Specialised Services Definitions Set (3rd ed.) No. 23 and sub-set 23.10 sets out the relevant patient groups.

**2.2 Service Description/Care Pathway**

  - Paediatric Intensive Care Transport is included within the SSNDS for Specialised PIC Services, Set No. 23.10 (3rd edition).

  - PIC Transport Services are a key component in the provision of children’s critical care where this is provided in centralised regional centres. In addition, a PIC Transport Service shall work across an integrated care pathway and in partnership with local referring centres to ensure that local assessment, stabilisation and management pre-retrieval is effectively provided, usually outside a dedicated ‘children’s critical care’ environment.

  - In some cases, due to imperative need, children will need to be transferred to a PICU by the referring team; however, this must be regarded as exceptional and the recommendation is that critically ill children are transferred by a specialised dedicated PIC Transport Service.

  - The PIC Transport service will usually operate road transport. However, on occasion due to either clinical or logistical reasons then transfer by air ambulance may be required. In that case this will be provided by a dedicated specialist Air Transfer Service and the PIC Transport Service must have policies and protocols in place to organise this. **Funding arrangements for air transport have not been clarified.**
• This service model will ensure that the transfer of children to a PICU is appropriate, organised and timely.

• The Transport Service shall provide:
  o Transport staff immediately available to the dedicated team.
  o Effective communications with the local referring centres to include a dedicated phone line and an operational policy for the referral management process.
  o Agreed transfer protocols for all referring centres within the catchment area.
  o Local agreements for the provision of an ambulance service.
  o Contingency plans in place in the case of the Retrieval Service, local PICU not available or vehicle breakdown/accident.
  o Indemnity and insurance arrangements.
  o Arrangements for Air Transport when that is required. This must be consistent with European Aero/Medical Institute (EURAMI)/CAMTS Standards.

This list is not exhaustive and further detail is outlined in ‘Standards for the Care of Critically Ill Children’ Paediatric Intensive Care Society (2010).

• Staffing must include the following:
  o A nominated lead consultant for the Retrieval Service
  o A lead nurse
  o 24 hour consultant advice and availability to join the retrieval team if necessary
  o A list of medical staff authorised by the lead consultant for Transport to undertake retrievals and to specify whether or not direct consultant supervision is required
  o A doctor appropriately trained and experienced to carry out retrieval available at all times
  o A list of nursing and other non-medical staff authorised by the lead nurse for Retrieval as appropriately trained and experienced to carry out retrievals and whether or not direct supervision is required.
  o A nurse or other non-medical member of staff trained and experienced to carry out retrievals should be available at all times.

The term ‘doctor’ used above will be interchangeable with ‘Advanced Nurse Practitioner’.
● General Paediatric care

When treating children, the Service will additionally follow the standards and criteria outlined in the Specification for Children’s’ Services (attached as Annex 1 to this Specification)

● Operational Delivery Network

There will be an Operational Delivery Network (ODN) expected for this service area, subject to further definition. ODNs will ensure quality standards and networked patient pathways are in place. They will focus on an operational role, supporting the activity of Provider Trusts in service delivery, improvement and delivery of a commissioned pathway, with a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of ‘Right Care’ principles by incentivising a system to manage the right patient in the right place.

● Levels of Care Across the Patient Pathway

o The Transport Service acts as a mobile intensive care unit to provide care to critically ill children. Referral to the Transport Service will be based on the child’s need for admission to a designated PCC bed (a PICU/PHDU). The responsibility for care by the Transport Service will pass from the referring service to the Transport team and back to the PCCU admitting the child following handover by the Retrieval team.

The 1997 ‘Framework’ utilised four levels of care, now replaced by seven HRG bands since the 2007 PCCMDS.

o In addition the Transport Service has an identified PCCMDS HRG code.

2.3 Population Covered

● Paediatric Intensive Care Transport Services are to be used for any patient that is to be admitted to a PICU or specialist HDU.

● The responsibility of the PIC Transport Service will include children requiring transfer from a general PICU to a specialist PICU, for example to be transferred for specialist treatment such as ECMO. The standards and service specification for ECMO services will be revised as a result of national review and the details are therefore not available at the point of writing.
Critically ill children are technically defined as those from 0 up to the age of 16 years; this shall include those discharged from a maternity service or neonatal unit and depending on the patient’s needs this exceptionally may extend to a wider age range.

Patients for transfer between neonatal units would usually be the responsibility of the Neonatal Transport Service.

The service outlined in this specification is for patients ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

2.4 Any Acceptance and Exclusion Criteria

**Neonatology**

The transfer of neonates will usually be undertaken by the Neonatal Transport Services. The Neonatal and Paediatric Intensive Care Transport Services may run as one service. However, where the two Retrieval Services are separate, where a neonate is being transferred for a surgical procedure and/or management on a PICU, then the neonate can be transferred by a Paediatric Intensive Care Transport Service.

It is important to note that in order to most effectively use the resources of both Services, consideration should be given to ‘overlap’ or a degree of integration for capacity reasons, particularly at times of high demand.

**General Ambulance Services**

General ambulance transfer to or from a PICU or designated HDU (i.e. not transferred by a dedicated specialist critical care retrieval team) is excluded from this specification.
• **Time Critical Transfers**

The PICU and PIC Transport Service shall develop and implement a local protocol for the transfer of critically ill children from a local referring centre to a PICU by a non PIC, non Transport Service team in the event of a necessary time critical transfer.

This protocol will outline specific example scenarios.

2.5 **Interdependencies with Other Services**

**Critical Interdependencies**

- Critical Interdependencies are PICUs, local referral centres, ambulance services, other, particularly adjacent PIC transport services and Neonatal Transport services.

- Dependent on the model of service provision there will be an essential interdependency with other Ambulance Services and Air Transport services.

- For PIC Transport, the integration with PIC services, PIC networks and the relevant Specialised Services and Networks for Children provide a link to parts of a wider care pathway.

3. **Applicable Service Standards**

3.1 **Applicable National Standards e.g. NICE, Royal College**

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4. Key Service Outcomes

- Accountability

  The process for retrieval of critically ill children must be fast and efficient, requiring a high degree of coordination between all service providers. The development of this coordinated approach must be led by the Transport Service, but should be wholly supported by the PICU and other local providers requiring transfer of patients to a PICU at any time.

  Seasonal Variation in Activity

  The typical peak of PICU activity between November and January each year can result in an increase in admissions by 20-30% for those months. The planning of the Transport Service must therefore account for this escalation in demand.

  Measures Required to Evidence Accountability

  - Agreed transfer protocols in place for all local referring centres
  - Agreed transfer contingency in place for each local referring centre within defined catchment
  - Requests for retrieval to which the PIC Transport Service is unable to respond will be monitored and audited
  - Mobilisation times in line with the National Quality Dashboard
  - The Transport Service will arrive at the local referring centre within three hours of the decision to retrieve the child.
  - Retrieval training will be conducted at least annually
  - Transport Services shall collect data on at least:
    - Referrals, including those not resulting in transfer
    - Referral information completeness
    - Advice to referring hospitals
    - Parent Communication, quality monitoring and audit
    - Pre-transfer patient condition and management
- **Retrievals**
- **Ambulance response times**
- **Untoward clinical incidents**
- **Mortality and morbidity**

**Outcome Measures**

- The Service dataset submitted within three months of patient retrieval will be evidenced in the Paediatric Intensive Care Audit Network (PICANet) Annual Report.
- Transport Services shall have arrangements in place for clinical review of cases including review with referring centres.
- The Transport Service will produce an Annual Report summarising activity, compliance with quality standards and clinical outcomes. Actions required to meet expected quality standards shall be identified and progress outlined since previous year’s annual report.
- *The report must be shared with referring centres.*
- The Transport Service must be assured that within the network the following is provided: education & training delivered to referring centres within the network will cover assessment, resuscitation, stabilisation and maintenance of critically ill and injured children prior to the arrival of the Transport Service.
- The Transport Service shall have arrangements in place to receive ongoing feedback from local referring centres.

**Paediatric Intensive Care Quality Dashboard**

The following measures are included in the National Quality Dashboard and specifically relate to Key Performance Indicators for a PIC Transport Service.

- **Number of retrievals performed within the locally agreed mobilisation time**
  - Timely mobilisation of PIC Transport Team (mobilisation time is recognised as the time from point of referral to departure from base)
  - Number of retrievals performed each month with mobilisation time less than or equal to 30 minutes.
  - Target will be 95% of retrievals.

- **Ability to deliver a 24 hr Retrieval Service**
  - Number of requests refused (within defined catchment) for retrieval of patients requiring PIC admission.
  - Target baseline to be set 2012/13.
• **PICA Net Data Compliance**

In addition to Quality Dashboard measures, the Retrieval Service must complete the PCCMDS to PICANet within 3 months of the date of retrieval. (See also paragraph 4.2). [http://www.picanet.org.uk](http://www.picanet.org.uk)
ANNEX 1 TO SERVICE SPECIFICATION:
PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

- This specification annex applies to all children’s services and outlines generic standards and outcomes that would fundamental to all services.
- The generic aspects of care:
  - The Care of Children in Hospital (HSC 1998/238) requires that:
    - Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
    - Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.
    - Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
    - Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
    - Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish.

Service description/care pathway

- All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.
- The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.
- Services should therefore be organised and delivered through “integrated pathways of care” (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004)

Interdependencies with other services

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – DH
Imaging

- All services will be supported by a 3 tier imaging network (‘Delivering quality imaging services for children’ Department of Health 13732 March 2010). Within the network:
  - It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
  - Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements
  - Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
  - Common standards, protocols and governance procedures will exist throughout the network.
  - All radiologists, and radiographers will have appropriate training, supervision and access to continuing professional development (CPD)
  - All equipment will be optimised for paediatric use and use specific paediatric software

Specialist Paediatric Anaesthesia

- Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training. All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training and should maintain the competencies so acquired. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

- As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

- Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

*The Safe and Sustainable reviews of paediatric cardiac and neuro-sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.
Specialised Child and Adolescent Mental Health Services (CAMHS)

The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following:

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic1.aspx)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person’s family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

Applicable national standards e.g. NICE, Royal College

- Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

References
1. GPAS Paediatric anaesthetic services. RCoA 2010 www.rcoa.ac.uk
2. CCT in Anaesthesia 2010
3. CPD matrix level 3
There must be at least two Registered Children’s Nurses (RCNs) on duty 24 hours a day in all hospital children’s departments and wards.

There must be an Registered Children’s Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

- Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes HBN 23 Hospital Accommodation for Children and Young People NHS Estates, The Stationary Office 2004.

- All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children’s Workforce Development Council Induction standards (Outcome 14b Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

- Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002). “Facing the Future” Standards, Royal College of Paediatrics and Child Health.

- Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

- Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a Essential Standards of Quality and Safety, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (Seeking Consent: working with children Department of Health, London 2001).

- Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:
  - Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
  - Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
  - Ensuring that people who use services are aware of how to raise concerns of abuse.
o Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.

o Having effective means of receiving and acting upon feedback from people who use services and any other person.

o Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:

  - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
  - separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
  - reporting the alleged abuse to the appropriate authority
  - reviewing the person’s plan of care to ensure that they are properly supported following the alleged abuse incident.

o Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.

o Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.

o Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.

o Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.

o Taking into account relevant guidance set out in the Care Quality Commission’s Schedule of Applicable Publications

o Ensuring that those working with children must wait for a full CRB disclosure before starting work.

o Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

- All children and young people who use services must be
  - Fully informed of their care, treatment and support.
  - Able to take part in decision making to the fullest extent that is possible.
  - Asked if they agree for their parents or guardians to be involved in decisions they need to make.

(Outcome 4I Essential Standards of Quality and Safety, Care Quality Commission, London 2010)
Key Service Outcomes

- Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS. Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and STIs, and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.

- Poorly planned transition from young people’s to adult-oriented health services can be associated with increased risk of non adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:
  - All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.

- The National Minimum Standards for Providers of Independent Healthcare, (Department of Health, London 2002) require the following standards:
  - A16.1 Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
  - A16.3 Toys and/or books suitable to the child’s age are provided.
  - A16.8 There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult patients; the segregated areas contain all necessary equipment for the care of children.
  - A16.9 A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child’s room or close by.
  - A16.10 The child’s family is allowed to visit him/her at any time of the day, except where safeguarding procedures do not allow this.
  - A16.13 When a child is in hospital for more than five days, play is managed and supervised by a qualified Hospital Play Specialist.
  - A16.14 Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.
  - A18.10 There are written procedures for the assessment of pain in children and the provision of appropriate control.

- All hospital settings should meet the Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, London 2010).
• There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:
  
  o A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
  
  o Food and hydration that meet any reasonable requirements arising from a service user’s religious or cultural background

  o Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

  o For the purposes of this regulation, “food and hydration” includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.

  o Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

• All paediatric patients should have access to appropriately trained paediatric trained dieticians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.

• All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate.

• All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 Essential Standards of Quality and Safety, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

  o ensure the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability

  o ensure that staff handling medicines have the competency and skills needed for children and young people’s medicines management

  o ensure that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

• Many children with long term illnesses have a learning or physical disability. Providers should ensure that:

  o They are supported to have a health action plan

  o Facilities meet the appropriate requirements of the Disability Discrimination Act 1995

  o They meet the standards set out in Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children’s to adult health services. Department of Health Publications, 2006, London