2012/13 NHS STANDARD CONTRACT
FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH
AND LEARNING DISABILITY SERVICES
(MULTILATERAL)

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No. | E9c | SSNDS 23.13
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Service | Paediatric Neurosciences - Neurodisability
Commissioner Lead | Barbara Howe
Provider Lead | 
Period | 12 months
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1. Population Needs

1.1 National/local context and evidence base

- Neurodisability is an umbrella term for conditions associated with impairment involving the nervous system and includes conditions such as cerebral palsy, autism and epilepsy; it is not uncommon for such conditions to co-occur. Children with a neurodisability have a range of impairments but many have complex and continuing need and as a result are frequent users of the health service at all levels, community, primary care inpatient and outpatient settings.

- Disability in children and young people is common. It is estimated from a Family Resource Survey 2004 / 5 that there are 952,741 disabled children in the UK. Disability in children (ukpmc.ac.uk/ukpmc/ncbi/articles/) which is 7.3% of the population of children and young people aged 0 - 18 years. This means that 8.8% of boys and 5.8% of girls are disabled. Many of these children and young people have difficulties in more than one area of daily living, with around a third experiencing two to four difficulties and more than 10% experiencing five or more difficulties. A number of recent reports have highlighted the inequalities and poor standards of care afforded to individuals with learning disabilities in the UK. (Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities. July 2008; Valuing people now.)

- Epidemiology: Many of the conditions that cause neurodisability that require care and specialist advice from specialist teams individually rare for example:
  - Neurometabolic disorders and neurodegenerative conditions Batten’s Disease (1 in 12,500 live births), ataxia telangiectasia (< 1 in 40,000),
  - Neurocutaneous syndromes e.g. tuberous sclerosis (< 1/ 100,000 live births);
  - PMLD groups e.g. Rett syndrome affecting less than 1 in 10,000.

- Other neurodisabling conditions are more common, e.g. the autism spectrum disorders affect ~1 in 100 of the population and the cerebral palsies ~1 in 400, severe intellectual disabilities ~3 in 1000. However, the range of associated conditions and nuances of individual presentation are such that specialist neurodisability expertise is required for accurate assessment and management. For example, 10-15% of all children and young people with cerebral palsies have developmental brain anomalies, some of which are genetically determined and may have implications for the wider family as well as implications for language and learning for the individual.

2. Scope

2.1 Aims and objectives of service

- The key aims of the service is to:
  - To improve the health outcomes for children and young people who have a neurodisability
  - Early, appropriate and cost – effective
  - Increase the focus on improving children’s lives by ensuring that professional work together across organisational boundaries to meet the needs of the young people.

- The key objectives are to:
  - To provide a high quality, timely consultant led medical service for children and young people with complex neurodisability for children and young people under the age of 19 (or during transition into adulthood)
  - Through the provision of a multi-disciplinary neurodisability service, children young people and their families health outcomes are maximised as a direct outcome of engagement with the specialist multi-disciplinary neurodisability team
To support the training strategy through the delivery of training to professionals in relation to neurodisability within the regional networks and other services, health, education, social etc.

To enable research this will provide the evidence base for future care.

To contribute to the collection of epidemiological data pertinent to disabled children and young people, including measures of outcomes.

2.2 Service description/care pathway

The service (part of an integrated multi-disciplinary team) will provide appropriate paediatric assessment, including full investigative and diagnostic service. The service will provide management for a range of related medical needs. High quality specialist child and family centred care will be delivered by appropriately qualified and skilled professionals.

The service will ensure that:

- Children and young people’s health outcomes are enhanced through access to a specialist paediatric multi-disciplinary neurodisability service.
- Children and young people who are living with a Long Term Conditions (LTC) and/or disability are proactively managed and as a direct result there is prevention of unnecessary exacerbation of symptoms and in turn reduction in avoidable acute hospital admissions. Hospital admission rates for disabled children and young people will be measured over time.
- Early diagnosis and interventions contribute positively to the reduction in late and potentially, more intense treatment of presenting conditions. Diagnostic rates for primary diagnoses and secondary disabilities could be measured and related to population denominators.
- The emotional health and wellbeing of children and young people who have a neurodisability is considered with appropriate support and referral.
- The service pathway is designed to enhance user experience, enabling access to a multi-disciplinary team where appropriate, thus reducing unnecessary appointments.
- The service applies proactive management approaches to improve the equity and accessibility of the service to promote engagement with the most vulnerable and hard to reach children and young people who have a Neurodisability
- A robust framework of safeguarding standards is applied within the service provision
- Advice and appropriate support is given to increase the knowledge and skills of staff in community health services, secondary and primary care who are responsible for providing services to children and young people who have a Neurodisability
- Patients are managed effectively within waiting time standards
• Onward referral and signposting is compliant with care pathways – and the neurodisability centre has a responsibility to ensure that this occurs

• Effective transition planning is managed in a timely manner

• The principles and standards outlined in national policy (for example – Standards within Children and Young People’s National Standards Framework (DH, 2004) are met to ensure and promote participation and cross agencies integration measured by PROMs

Families experience seamless care, including provision of appropriate equipment across all settings.

The service will be available to all patients who meet the referral criteria and offers:

• Medical (multidisciplinary) assessment including full investigation and diagnostic service, on-going management for associated medical needs e.g. respiratory problems, epilepsy, feeding and nutrition, constipation, challenging behaviour and medical management of spasticity.

• Development of care pathways with networks

• Liaison with partner agencies to promote and enable a coordinated package of support agreed with families (therapy, education, early years education teams, social care, voluntary sector)

• Provision of outreach support for the care package including specific therapeutic input if not locally available e.g. Botulinum toxin treatment, challenging behaviour strategies, psychopharmacology; respiratory, enteral feeding etc.

• Transition planning (from age 14 years) into suitable adult Leading and coordinating research into translational care to provide the evidence base for treatments.

Specialised neurodisability services will be delivered by a variety of professionals with the necessary competencies:

• Paediatricians trained in neurodisability and neurology will be the core deliverers of care.

Essential components of the multidisciplinary network team will be:

• Paediatric physiotherapy

• Paediatric occupational therapy

• Paediatric speech and language therapy and assessments including for communication, social communication, augmented and assisted communication, dysphagia, feeding and swallowing.Paediatric neuropsychology and neurocognitive assessments/educational psychology
• Child psychiatry and neuropsychiatry
• Neurophysiology
• Dietetics
• Mobility, wheelchair and specialised equipment services
• Paediatric surgery e.g. orthopaedics, gastroenterological
• Sleep specialists
• Children’s nursing (children’s community nurses, learning disability nurse specialists, epilepsy nurse specialists etc.)
• Specialist teachers—e.g. hospital schools, specialist teachers for those with sensory impairments, specialist teachers with expertise in information and computer technologies, specialist teachers with expertise in autism-specific teaching and communication strategies.

The service will have access to the following co-dependencies:
• Paediatric neurology
• Paediatric neurosurgery
• Paediatric ophthalmology and orthoptics
• Ear, Nose and Throat and audiology
• Paediatric gastroenterology
• Paediatric surgery and urology
• Paediatric endocrinology
• Neuro-imaging
• Neurophysiology
• Clinical genetics, cytogenetic and molecular genetics
• Sleep laboratory studies
• Specialist biochemistry, haematology, microbiology laboratory investigation.

All the above will need to be available at an inpatient and outpatient level.

Specialised conditions covered by this specification are described in Appendix 1.

The service provided by a specialist neurodisability centre will include the following interventions:
• Intrathecal baclofen
• Selective Dorsal Rhizotomy, Complex neuropsychiatric assessments e.g. autism, ADHD, with co-morbidities, marked behaviour needs
• Spinal dysraphism disability interventions
• Vagal nerve stimulation (VNS)
• Deep brain stimulation - currently only accessible for children in a few centres
• Botulinum toxin treatment
• Co-ordination of support with respiratory specialists when breathing is significantly compromised
• Sleep studies and interpretation
• Dietetic, feeding assessment and gastrostomy support
• Case management support for families with particularly complex problems

Some conditions can be managed by a shared care arrangement between the local hospital or neurodisability paediatrician and the by a specialist neurodisability centre.

All disabled children and young people need health care as close to home as is possible. Paediatric neurodisability is a relatively new subspecialty and as such does not fit neatly into the conventional model of secondary and tertiary care as there are trained and competent paediatric neurodisability specialists working in district hospital and community settings as well as in tertiary centres.

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).

2.3 Population covered

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.
The service will be available for all children with a neurosurgical condition up their 19th birthday. Neurosurgical Networks will evolve in 2012 covering the whole population of children in England.

2.4 Any acceptance and exclusion criteria

The Lead Paediatrician will initiate a referral to a specialist centre and referral to a specialist centre and referrals will also be made from:

- Neonatal services
- Paediatric and Specialist Consultants
- Paediatric Neurology and neurosurgery teams

Several of the interventions offered by the specialist neurodisability team have clear eligibility criteria as described in national guidelines of good practice e.g. ITB.

Exclusion criteria: Patients not meeting referral criteria will be excluded.

Discharge planning will be carried out through early engagement with child, young person, parents/carers and other services. Children with a LTC, chronic illness or disability will have a care written care plan and may be treating according to the individual conditions care.

2.5 Interdependencies with other services

To the needs of the client group there is a requirement to work proactively with a range of partners and key stakeholders, including primary care, general practitioners, Children’s Social Care, Adult Health and Social Care and non-NHS agencies to ensure appropriate referrals, fast response times and high quality patient care.

Stakeholders and interdependencies will include outreach advice and support to:

- Parents /carers in their homes and the CYP themselves at appropriate age
- Midwifery services
- Neonatal services
- Children Centre facilities staff
- GP’s
- CAMHS
- Social services - children and young people’s teams
- Education services
- Third sector providers of children’s services
- Carer support services
- Therapy services (OT, Physio & SALT), nursing teams in community locally.
3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Policy guidance: National

- Safe and sustainable
- Children’s neurological services in England a framework for the future. 2011
- BPNA guide for purchasing tertiary paediatric neurological services 1998
- DH (2009) Healthy Lives, Brighter Futures
- DH (2007) Mental Health Act
- DH (2006) Our Health, Our Care, Our Say: a new direction for community services
- NICE diagnosis of ASD
- NICE Epilepsy in childhood
- NICE ADHD
- Early support programme

Spasticity - Botulinum toxin treatment, Intrathecal baclofen programmes and SDR assessment and surgery according to NICE guideline recommendations.

Complex epilepsy according to NICE definitions

Spinal and neuro muscular disability e.g. Duchenne (1 in 12000 sporadic) and spina bifida and associated conditions
Complex neurodevelopmental disorders with neuropsychiatric problems and multiple co morbidities e.g. ASD plus ADHD, plus LD plus or minus epilepsy., severe speech communication disorders.

4. Key Service Outcomes

- Through the provision of a multi-disciplinary neurodisability service children, young people and their families health outcomes are maximised as a direct outcome of engagement and proactive management by the specialist multi-disciplinary service provided by the Neurodisability and related Clinics
- Parents/carers (and siblings) are enabled to cope effectively with the child’s complex health and emotional needs
- Through early diagnosis and intervention children and young people experience a reduction in late and often more intense treatment requirements for their condition
- The emotional needs of children and young people are anticipated with appropriate support and referral to the range of Child and Adolescent Mental Health Services where appropriate with referral through CAMHS SPA (this includes targeted provision with a nurse specialist in disability and emotional wellbeing)
- With appropriate consent, co-ordination and dissemination of information relating to specific children and young people is facilitated by appropriate attendance at multidisciplinary and multi-agency team meetings
- There is a clear processes for safeguarding which is applied in line with a national and local safeguarding policy
- All training delivered is evaluated and is of high quality
- Rates of diagnoses for sentinel conditions e.g. cerebral palsies, severe learning disabilities (defined here as IQ<50), autism spectrum disorders should be available and related to population denominators.
- Rates of specific diagnoses for those with a severe learning disability should be available and related to population denominators.
- Rates and durations of hospital admissions for those with sentinel conditions should be available and related to population denominators.
Appendix 1:

Conditions managed by a specialist neurodisability centre include:

- Diagnostic confirmation
- Severe dystonic postures
- Complex care packages (e.g. children requiring 1 to 1 healthcare support in the home)
- Children requiring home ventilation for neurological causes including neuromuscular illness and specialist equipment
- Severe epilepsy with challenging behaviours
- Complex neurodegenerative conditions with loss of skills
- Sensory loss with vision and hearing loss.
- Severe communication needs that require alternative and augmented communication systems
- Paediatric neuro-rehabilitation following traumatic or non-traumatic acquired brain injury (ABI) and acquired spinal cord injury (ASI), inc. post-surgery.
- Behavioural/cognitive/neuropsychological rehabilitation programmes
- Management of spasticity
- Dysphagia management and investigations including video fluoroscopy
- Assistive technology, including environmental control and powered mobility
- Spinal/postural management in children with complex motor disorder
- Assessment and multidisciplinary management of children with neuropsychiatric conditions including chronic pain and functional disorders.
- Diagnosis and management of uncommon syndromes and developmental problems requiring paediatric neurology and specialised neurodisability services.
- End of life care for the child with complex neurodisability
- Severe sleep problems in CYPs with LTCs and disability
- Intellectual disorders with challenging behaviours
- Any neurodevelopmental disorder with complex additional medical or behavioural disorders
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:

  o 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.
  o 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.
  o Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
  o Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
  o 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 – Department of Health (DH)
• Imaging
  o All services will be supported by a 3 tier imaging network (‘Delivering quality imaging services for children’ DH 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
    ▪ All equipment will be optimised for paediatric use and use specific paediatric software

• Specialist Paediatric Anaesthesia
  o 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.¹ 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) training² and should maintain the competencies so acquired³ *. 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).
  o 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.
  o 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.

- **References**
  1. GPAS Paediatric anaesthetic services. RCoA 2010 www.rcoa.ac.uk
  2. CCT in Anaesthesia 2010
  3. CPD matrix level 3

- **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)
  - 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).
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.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- 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.
- 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.
- 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.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission’s Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
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:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users’ needs;
- Food and hydration that meet any reasonable requirements arising from a service user’s religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, “food and hydration” includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.
- 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 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:

- Ensures the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- Ensuring that staff handling medicines have the competency and skills needed for children and young people’s medicines management
- Ensures 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:

  - They are supported to have a health action plan
  - Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
  - 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, 2006, London